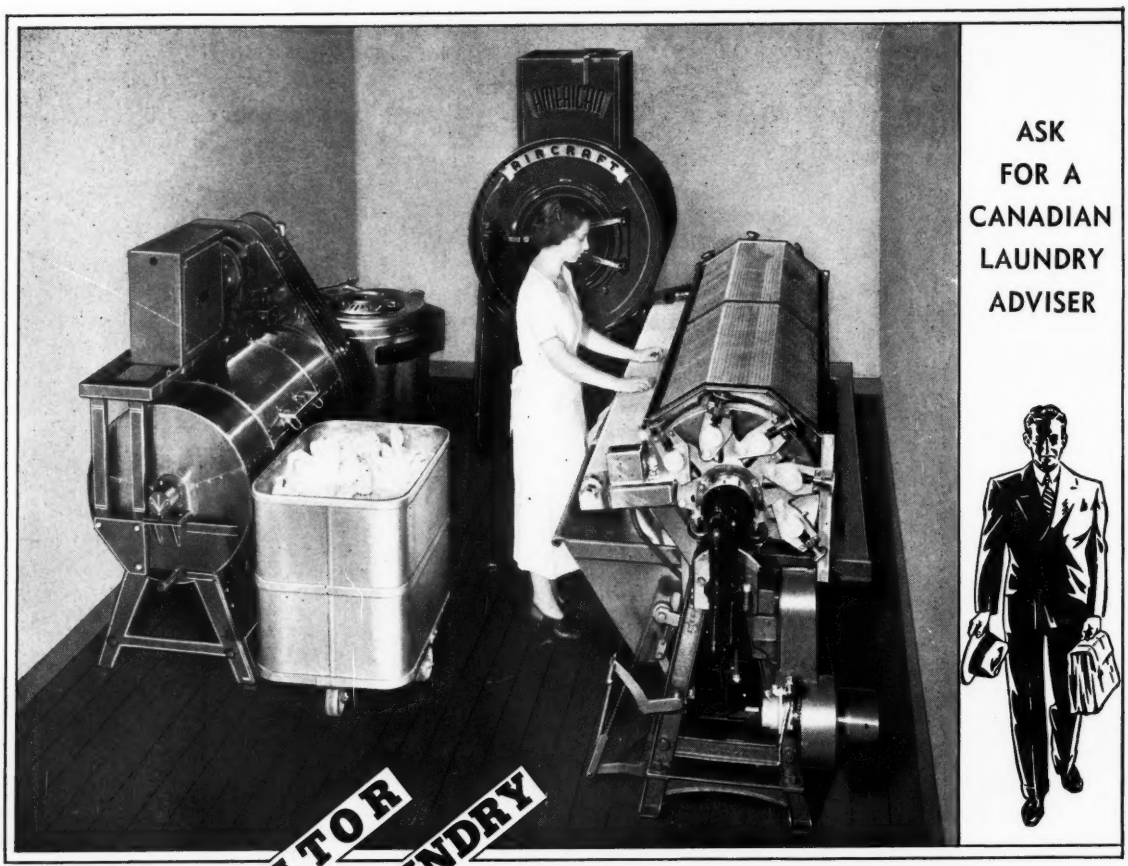
THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

SEPTEMBER, 1944



ASK FOR A CANADIAN LAUNDRY ADVISER

THIS ONE-OPERATOR FOUR-MACHINE LAUNDRY

may be the long-looked-for solution *to your* soiled linen problem

The CANADIAN 4-MACHINE LAUNDRY is so simple and easy to operate that in many small hospitals one girl does all the laundering. No more experience, and far less effort, is required to operate the CANADIAN 4-MACHINE LAUNDRY than equipment designed for household use.

While 25 to 30 sheets, or their equivalent are washed sterile-clean in the washer, the same amount of previously washed work is having excess water removed in the efficient Monel metal extractor. Simultaneously, the same amount of work is being fluffed completely dry (predried for fast ironing) in the AIRCRAFT Tumbler.

These three machines require so little of the operator's attention that she devotes most of her time to the ironer, where linens are beautifully finished, ready to return to service. All of this is done in a space no larger than the average private patient's room.

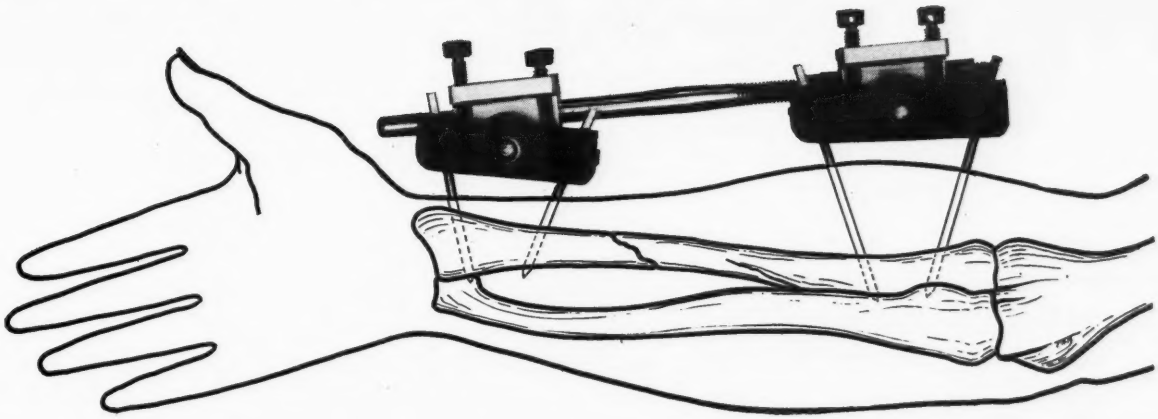
Result is that an ample supply of clean linens is always available for every emergency. Yet a lower linen inventory can be maintained . . . Is it any wonder so many small hospitals find the compact, inexpensive CANADIAN 4-MACHINE LAUNDRY the long-looked-for solution to their soiled linen problem?

Our free, non-obligating Laundry Advisory Service will definitely verify, or disprove, the adaptability of the CANADIAN 4-MACHINE LAUNDRY in your particular case. Why not have a Canadian Laundry Adviser call and determine if the CANADIAN 4-MACHINE LAUNDRY can benefit you? You may be pleasantly surprised. Write.

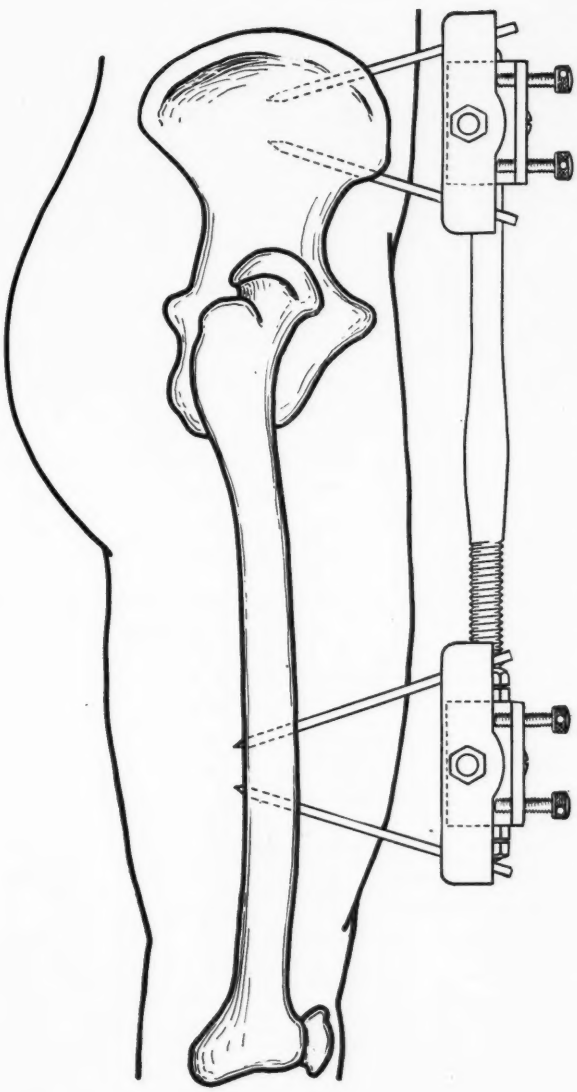
The

CANADIAN LAUNDRY MACHINERY CO. LIMITED

47-93 STERLING ROAD, TORONTO 3, ONT.



Designed to Facilitate EXTERNAL FIXATION OF FRACTURES



Stader Reduction and Fixation Splint Requires No Auxiliary Equipment

Surgeons who are using the Stader Splint frequently comment on the comparative simplicity of its application, since it does not require an extension apparatus, nor special frame or fracture table, nor plaster cast.

Because of its intensely practical design, the Stader Splint provides not only mechanical reduction of the fracture, but its adjustable connecting bar assembly also acts as the splint upon completion of the reduction.

The unusual accuracy in reduction and rigid uninterrupted fixation assured with this instrument, and the complete articular freedom it affords above and below the fractured member (thus minimizing joint disability due to immobilization), are distinct advantages which both surgeon and patient appreciate.

A thorough investigation of the Stader Splint offers interesting comparisons with other methods of external skeletal fixation.

Write today for Pub. No. K89.

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Vol. 21 **SEPTEMBER, 1944** No. 9

The Canadian Hospital is the Official Journal of The Canadian Hospital Council

CCAB

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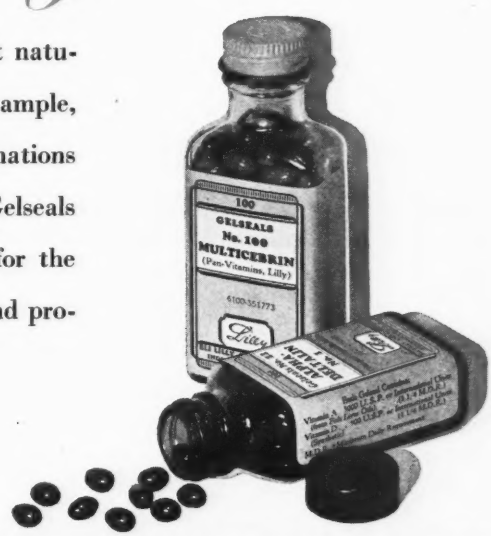
LILLY VITAMIN PRODUCTS in the prescription department naturally attract the prescribing physician. Gelseals, for example, exhibit the individual fractions as well as the logical combinations of vitamins in small, immaculate, gelatin-sealed ovals. Gelseals are carefully stabilized, highly potent, and economical for the patient. Like all Lilly products, gelseals are advertised and promoted through professional channels exclusively.



Lilly

ELI LILLY AND COMPANY (CANADA) LIMITED • TORONTO, ONTARIO

Canadian Hospital Council

The Federation of Hospital Associations in Canada in co-operation with the Federal and Provincial Governments and the Canadian Medical Association

manpower

from women

WAR INDUSTRY requires a colossal supply of manpower. Already a large percentage of it is provided by a working army of women.

Doing men's work, they will need the stamina of men to perform vital tasks with sustained efficiency. Moreover, the war will demand the best efforts of millions of women engaged in farm, household and home defense work.

'Riona' Capsules can improve the efficiency of female workers by combating the physiologic "slow-down" periodically experienced by most normal women between the ages of fourteen and forty-five. 'Riona' Capsules contain 'Propadrine' hydrochloride, ¾ gr., acetophenetidin, 2 gr., and aspirin, 3 gr. In the treatment of dysmenorrhea, the analgesic effect of aspirin and acetophenetidin is aided by the antispasmodic action of 'Propadrine' hydrochloride on the myometrium.

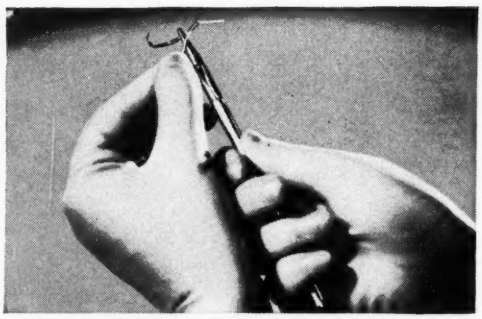
• • •

'Riona' Capsules are also indicated for the symptomatic relief of headache, neuralgia, rhinitis and malaise associated with hay fever or the common cold. 'Riona' Capsules, individually wrapped in cellophane, are supplied in boxes of 100. **Sharp & Dohme (Canada) Ltd., Toronto 5, Ontario.**

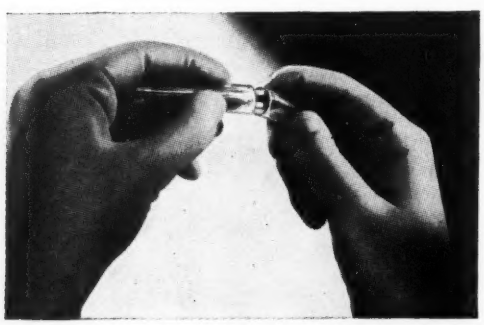
'RIONA' *Capsules*

TECHNIQUE of handling sutures in the operating room

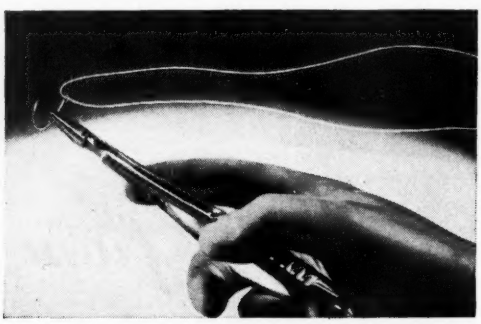
Important to the surgeon is the care with which sutures are handled and prepared for his use. A few simple steps assure that the Ethicon Suture he relies upon when he buries it in his patient's tissues will have the same dependable qualities of the tested suture sealed within the tube. Illustrated on this page are practical methods which are generally followed to protect the integrity of the strand.



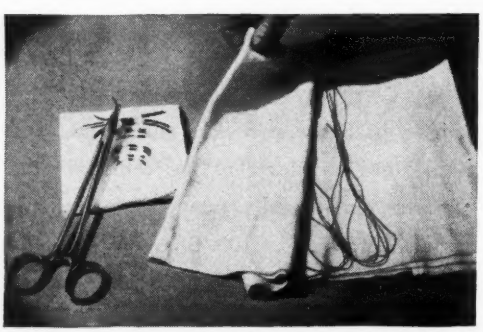
● Some surgeons and nurses prefer to thread a curved needle from the inside, in the belief that it prevents suture from slipping. When a suture slips, it may be damaged and may have to be rethreaded, causing loss of time and material.



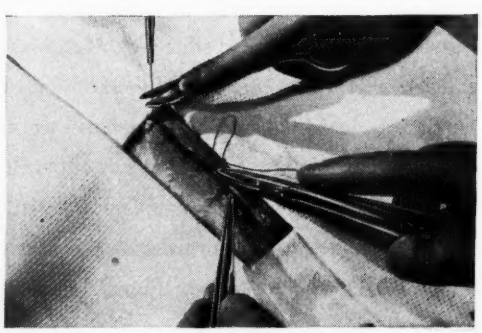
● Before tube is opened, reel is shaken into one end. This position keeps suture away from broken glass edges, which might easily scrape and damage the suture



● Orthodox position of needle in needle holder, permitting full bite into tissue. Grasping needle away from eye prevents possibility of crushing suture and eye of needle.



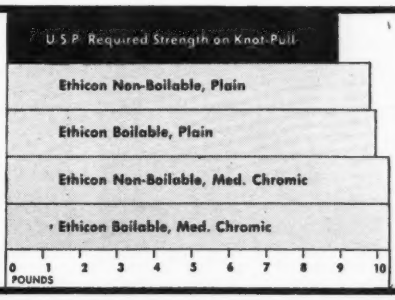
● Sterile sponge and moist towel technique for protection and convenience while sutures await threading to various needles required by surgeon as the operation progresses.



● In holding a suture, care is taken not to apply hemostat or crushing forceps to any portion of suture to be left in situ, eliminating possibility of leaving damaged suture in tissue.

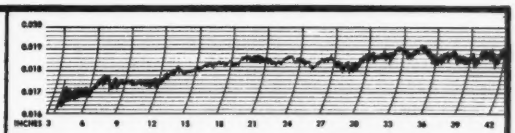
UNIFORMITY OF TENSILE STRENGTH

This chart gives an example of how uniformly Ethicon Surgical Gut exceeds U.S.P. requirements. The chart shows averages on knot-pull breaks on samples from lots, numbering hundreds of thousands of individual tubes, released by the J & J Laboratories.



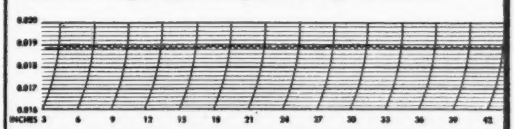
UNIFORMITY OF GAUGE

Johnson & Johnson's exclusive Tru-Gauging Process gives uniformity of gauge as well as greater uniformity of tensile strength. The graphs at right, made on a photoelectric microgauge, show that a hand-polished suture meeting U.S.P. requirements may vary in diameter more than 6 times as much as an Ethicon Suture.



HAND-POLISHED SURGICAL GUT SUTURE
Meeting U.S.P. Requirements

Size 1, charted by the photoelectric microgauge, shows diameter irregularities along entire length of strand.

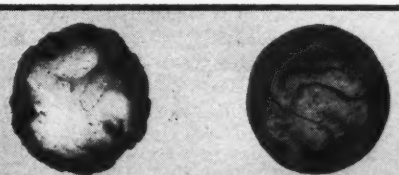


ETHICON TRU-GAUGED SURGICAL GUT SUTURE

Size 1, charted in same manner by the microgauge, shows gauge uniformity resulting from Tru-Gauging Process. This gauge-uniformity gives greater uniformity of strength by eliminating "low spots" that cause weakness.

TRU-CHROMICIZING

Tru-Chromicizing (exclusive with Ethicon Sutures) resists premature absorption. Many sutures are chromicized merely on the surface. Note the even distribution of chrome throughout the Ethicon Suture cross section.



CHROME-DIPPED SUTURE

ETHICON TRU-CHROME SUTURE

ETHICON

LOCK KNOT

SUTURES

Johnson & Johnson
LIMITED MONTREAL

World's Largest Manufacturer of Surgical Catgut

Social Security?... Why we've had it for years at Dominion Oilcloth!

Dave, an old-timer at Dominion Oilcloth & Linoleum Company, is talking to John, a new-comer.

DAVE: Yes, we've had social security here for years.

JOHN: But I don't understand. Isn't this unemployment insurance a new thing?

DAVE: Yes, it is—and a good thing, too. But the best unemployment insurance is a job—and work to do. And that's what we've had at Dominion Oilcloth & Linoleum.

JOHN: Sure we've got jobs now, but there's a war on.

DAVE: Right you are—but I mean in peacetime, too. Why, even through the last depression, employment here was kept at a high level. I lost little time—and that goes for most of us.

JOHN: Well, what about after the war?

DAVE: I'm not worried about that either. I figure there's going to be plenty of linoleum needed after the war. Think of the new homes this country will have to build, all the new schools, hospitals, offices, institutions.

JOHN: Well, it sounds good.

DAVE: And here's another thing—we have an employees' association of our own, and the company has sponsored a pension plan, sickness and accident insurance as well as many other benefits. They've always tried to keep their employees both busy and happy.

JOHN: Yes, I see now what you mean about social security being an old story to Dominion Oilcloth.

• • •

Quality goods at prices that compare favourably with prices prevailing in other countries, have resulted over the years in a steady demand for Dominion Oilcloth & Linoleum products. These factors, plus an understanding employee-relations policy, have provided security for Dominion workers. The executives of this company are busy now with plans to provide steady employment for its workers after the war.

Huge Dominion hydraulic linoleum presses are shaping hundreds of thousands of metal aeroplane parts.

Miles of war fabrics have been proofed against water, flame, mildew, gas and arctic weather

And linoleum for naval vessels, air force schools, training establishments, munitions plants, etc.

BUILDING FOR WAR • PLANNING FOR PEACE

DOMINION OILCLOTH AND LINOLEUM

COMPANY LIMITED

MONTREAL CANADA

Manufacturers of Dominion Battleship Linoleum and Marboleum

Across the Desk

By C. A. E.

Weather-ometer Tests Paints

AN ingenious little machine that goes by the name of a Weather-ometer helps the paint-conscious Ontario Hydro-Electric Commission to get a fair advance idea of how any particular type of paint is going to stand up under Ontario weather.

The Weather-ometer is a drum-like instrument in which various paints on test are coated onto a metal panel and then subjected to rays from a carbon arc lamp and passed through a stream of water every half hour as the drum revolves.

"For interior work, a paint is required to withstand this exposure without excessive "chalking" for 350 hours and must not develop noticeable cracking or spotting after 450 hours' exposure," explains T. H. Chisholm, of the Hydro laboratory. "Experience has shown that paints which start to crack after 200 or 300 hours in the Weather-ometer will do the same after 18 months on an interior wall if exposed to much sunlight."

For exterior paints, the test is much stiffer. Such paints have to stand up under the Weather-ometer conditions for upwards of 2,000 hours before the Commission is satisfied that they are suitable to withstand the rigors of Canadian summers and winters.

Transmutation of Wood

Although almost 300 species of trees are found in Canada, only about 30 to 35 are used commercially. Some are not used because they are too soft, or weak, or crush or dent too easily, are not durable, or present working, turning or finishing difficulties. But, according to the Canadian Industries Limited magazine, C-I-L Oval, a new process will bring many of these into the range of usefulness. In fact, it is said, perhaps no chemical discovery made during the past five years offers greater potential benefit to the Dominion than that announced recently, namely, a process for the transmutation of wood.

Simple impregnation with comparatively abundant and inexpensive chemicals synthesized from coal, water, and air transforms ordinary wood, the oldest material used by man, into substances as different from the original as steel is from iron. The process reconstitutes wood to order. It enables industry to create in a few days wood harder than ebony, which nature takes a century or more to grow.

Sea Water Soap

With the aid of a new soap made from petroleum, the U.S. Army is now able to wash itself in cold sea water. This "soapless soap" removes dirt, grease and oil when used in any kind of water. While not available for civilian use during the war, it should eventually prove a boon to hospitals, industrial plants and in homes in many localities where water conditions are, it might be said, a "detriment to clean living".

Major David Bell Ill

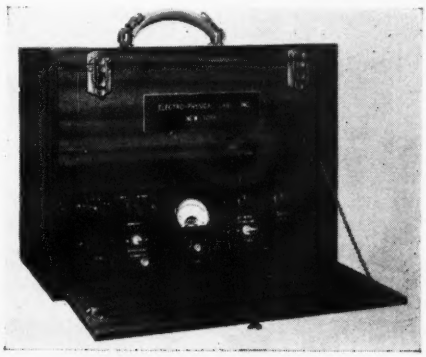
The many friends of Mr. David Bell of the Metal Craft Co., Limited, of Grimsby, until recently Major David Bell of His Majesty's Forces, will hear with regret that he is now confined to bed at Christie Street Hospital in Toronto. We wish him a full and speedy recovery from his operation.

* * *

Inkless, Direct-recording Electrocardiograph

After years of experimentation and research, the Electro-Physical Laboratories, Inc., New York, N.Y., has designed and developed an inkless, direct-recording Electrocardiograph giving instantaneous standard readings.

Built to exacting laboratory standards, the new



EPL Electrocardiograph has been designed to eliminate all photographic procedures, the manufacturers state. The cardiograph record appears instantaneously for interpretation at the bedside. Absolutely accurate standard readings are provided. Ordinary interfering electrical fields do not affect the operation. The Electrocardiograph is compact, lightweight, and portable. It is highly desirable for surgical procedure and pharmacological investigation. Many additional features include high operating economy, use for continuous recording and permanent records. The Electrocardiograph is highly useful for laboratory research and experimentation.

* * *

Upjohn Company a New Advertiser

Beginning with this issue, we are glad to add to our list of advertisers The Upjohn Company of Kalamazoo, Michigan, makers of fine pharmaceuticals since 1886.

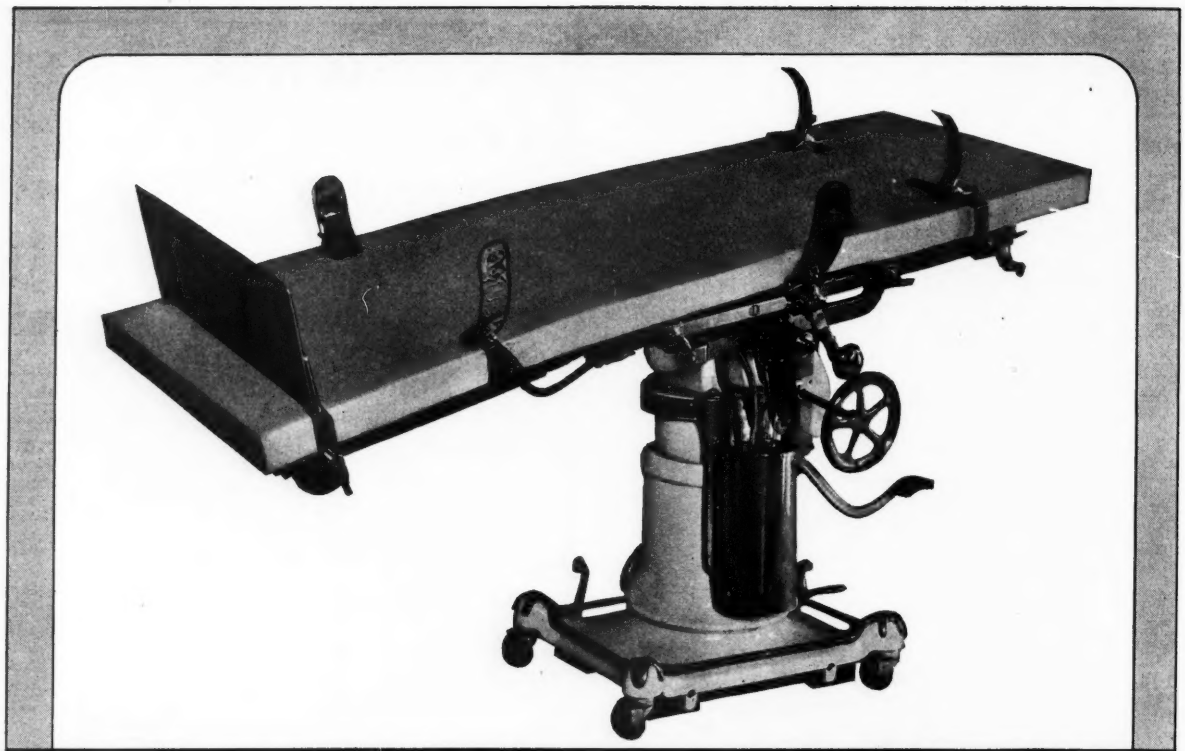
The Company's Canadian branch is located at 384 Adelaide Street West, Toronto.

* * *

Newman's Kitchen Equipment Catalogue

We are in receipt of a copy of Catalogue "A" issued by S. H. Newman Co. Limited, Toronto, which illustrates and describes an extensive range of kitchen equipment. Included are Coffee Urns, Cooks' and Bakers' Tables, Steamtables, Sinks, Dishwashing Machines, Trucks, Dish Racks, Electric Ranges and Ovens, Cast Aluminum Cooking Equipment, Refrigerators, Bread Slicers, Potato Peelers and utensils.

A complete planning service is available to hospitals and allied institutions.



"DUNLOPILLO"

Foamed Latex

CUSHIONING

IS STILL AVAILABLE

FOR ESSENTIAL HOSPITAL SERVICE

YES, this famous resilient and hygienic Cushioning is still available for the welfare of your patients and the efficiency of your hospital. Owing to the war, however, the supply is limited to serving only essential hospital needs.

May we suggest, then, that you continue to take care of the "Dunlopillo" Foamed Latex Cushioning you now have and, if any of these items . . . Orthopedic Cast Padding Material, Operating Table Pads, Obstetrical Table Pads, Ambulance Stretcher Pads . . . are among your urgent requirements, let us know promptly and we will do our utmost to serve you.

When Victory has been won, "Dunlopillo" Foamed Latex Cushioning will again be available to you in full and unlimited selection. Even now we are planning for that day . . . using the knowledge gained in the pressure of war research and production . . . concentrating on improving even the present high standards . . . so that, after the war, "Dunlopillo" Cushioning will make a greater contribution than ever to the work of doctors and hospitals.

DUNLOP-CANADA

Aetna Stills and Sterile Water Plants

Two new products have recently been designed by Aetna Scientific Co., Cambridge, Mass. The first is the Aetna Vertical Solutions Still for hospital and laboratory work. The distillate in this still is fed into a specially constructed pyrex receiver; pure water is drawn through the receiver from a pyrex valve; in this way a constant supply of freshly distilled water is ready for immediate use. The unit is built as a single unit mounted on a wall bracket.

The second product recently developed by this company is the Double Purpose Sterile Water Plant. This model consists of a combination water still and sterilizer which produces bacteriologically and chemically pure water. Incorporated into one unit are all the services of a separate water still producing distillate of utmost purity and a water sterilizer providing pure water for surgical use. The necessity of shutting down the unit intermittently to filter water into the tanks is avoided and operation is continuous and automatic.

* * *

Clay-Adams' New General Catalogue

The Clay-Adams Company, New York, have just issued a very complete catalogue including not only their Surgical and Laboratory Items, but also OB Manikins, Anatomy Charts, Atlases, Chase Hospital Dolls, Skeletons, Skulls, Kodachrome Supplies, and Kodachrome Lantern Slides.

Particular attention is directed to the Medichrome Section consisting of approximately 2500 2 x 2″ Kodachrome slides for teaching normal and pathological histology, nursing procedures, tropical diseases, and other subjects of interest to teachers in the medical, nursing and biological sciences.

Mr. Lloyd T. Hilborn, President, states that this 144-page catalogue includes many new items which have not previously been catalogued.

* * *

Insulation Becomes Transparent

Utilizing the proven principle of captured air spaces, Thermopane, a new type of glass, not only conquers heat loss, but adds the invaluable property of transparency.

Thermopane has been made possible partly by the versatility of glass and partly by the discovery of a new process which welds copper to glass with an impenetrable seal. Two or more sheets of glass are held about one-quarter inch apart with the metal seal and between the sheets dried air is permanently imprisoned. The infra red rays of the sun pass through as usual, but heat stays where it is wanted.

As a storm glass, Thermopane supersedes outdated methods because the inner surfaces never need cleaning and the annual putting up and taking down of extra windows is unnecessary.

While it is ordinarily made with plain glass, Thermopane is also obtainable with armourplate glass to resist unusual shock hazards. It is also produced in figured glass which adds decorative beauty to its other properties.

On application, Hobbs Glass Limited, London, Ont., will send a complete descriptive book.

Confirming Data — Expanding Use

Successful clinical experience, as reported in leading medical journals, has greatly broadened the interest in Amino Acid therapy. With a fuller appreciation of this therapeutic agent, physicians are rapidly extending its use to combat protein malnutrition.

Production facilities, recently expanded to meet these growing requirements, enable us to supply adequate quantities of Parenamine (Amino Acids Stearns)—a reliable intravenous therapeutic to restore the nitrogen balance.

Parenamine

Amino Acids Stearns

Available for parenteral and oral administration as a 15% solution in 100 cc. rubber-capped vials. Details of therapy available on request.

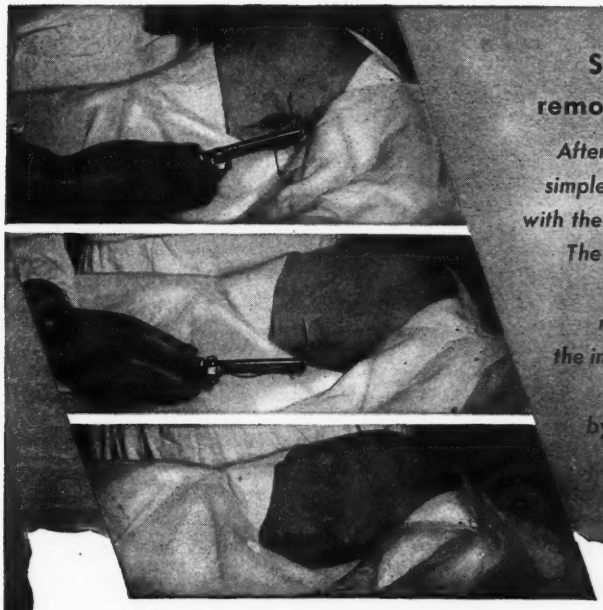
Trade Mark Parenamine Registered

Frederick Stearns ***& Company***

OF CANADA, LIMITED

Since 1884 . . . ESSENTIALS OF THE PHYSICIAN'S ARMAMENTARIUM

NEW YORK KANSAS CITY SAN FRANCISCO DETROIT, MICH. **WINDSOR, ONTARIO** SYDNEY, AUSTRALIA AUCKLAND, NEW ZEALAND



Skin closure following removal of Benign Neoplasm

After excision of the new growth, simple interrupted stitches are placed with the Singer suturing instrument. The spool (under the operator's thumb control) feeds the thread as required; each knot is tied without the instrument leaving the operator's hand; and the strand severed by the knife-like edge of the lance-pointed needle.

...in minor surgery, too— a welcome "THIRD HAND"

Not only in more elaborate surgical procedures, but in the extensive field of every-day surgery—in which, by necessity, preparations and equipment are less elaborate, and well-trained assistants seldom immediately at hand — the Singer Surgical Stitching Instrument proves a real boon to the busy physician.

This complete, all-purpose suturing device frees the operator from "hand-to-hand" dependence on surgical assistants, enhances his deftness and precision, and extends the varieties of stitches available for his discriminating choice.

Suturing proceeds with greater speed—effecting firm reapposition of related structures with less local trauma.

The many leading surgeons who have adopted this modern suturing technique testify to its wide versatility, and its very real helpfulness.

The coupon is for your convenience in requesting descriptive brochure.

SINGER

SURGICAL STITCHING INSTRUMENT

—unites needle, holder, suture supply, and severing edge in one self-contained instrument, sterilizable as a complete unit.

Singer Sewing Machine Company
Surgical Stitching Instrument
Division, Canada Dept. C.H. 9

Without obligation, send copy of illustrated brochure.

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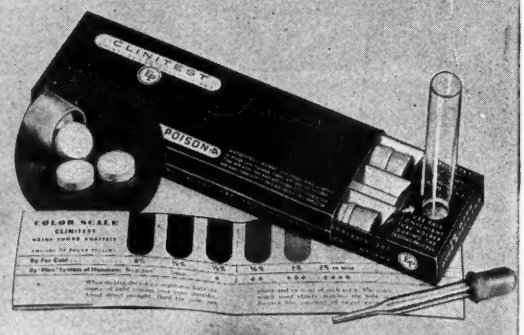
254 Yonge Street, Toronto • 424 Portage Avenue, Winnipeg • 700 St. Catherine Street W., Montreal

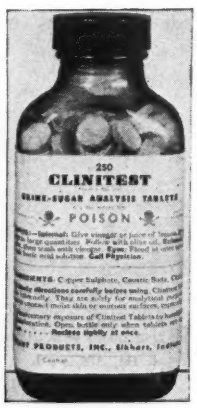
URINE-SUGAR DETERMINATIONS
Are Now Simplified

CLINITEST
A TABLET COPPER REDUCTION METHOD



Eliminates Heating... Measuring of Reagents and Complicated Apparatus

The Simple Technique . . .



1. Squeeze 5 drops (¼ C.C.) of urine into test tube.

2. Add 10 drops (½ C.C.) water.

3. Drop one Clinitest Tablet into test tube... that is all.

Allow for reaction . . . then compare with color scale which indicates sugar content up to 2 per cent.

FAST... CONVENIENT... ECONOMICAL

Clinitest is thoroughly dependable. It is a simplified modification of the well-known Benedict copper reduction method. The use of test tube confines the test to the known agents and reagents. It guards the test from possible oxidation by atmospheric oxygen.

The Complete set . . . as illustrated above . . . is self-contained. Is equipped with enough Clinitest Tablets for 50 tests. Costs the patient $1.75. Tablet Refills (for 75 tests) $1.75.

Available through your surgical supply house or prescription pharmacy.

Write for full descriptive literature.

Bottle of 250 Tablets

Clinitest for hospital use is available in bulk quantities of 1,000 and 3,000 tablets at special prices.

Orders for 1,000 are filled with 10 bottles of 100 tablets; while orders for 3,000 are filled with 12 bottles of 250 tablets.

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EFFERVESCENT PRODUCTS INC.

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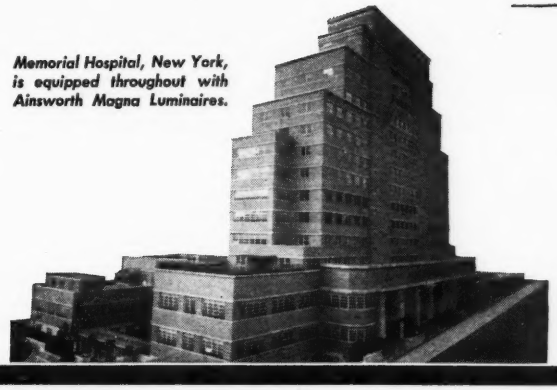

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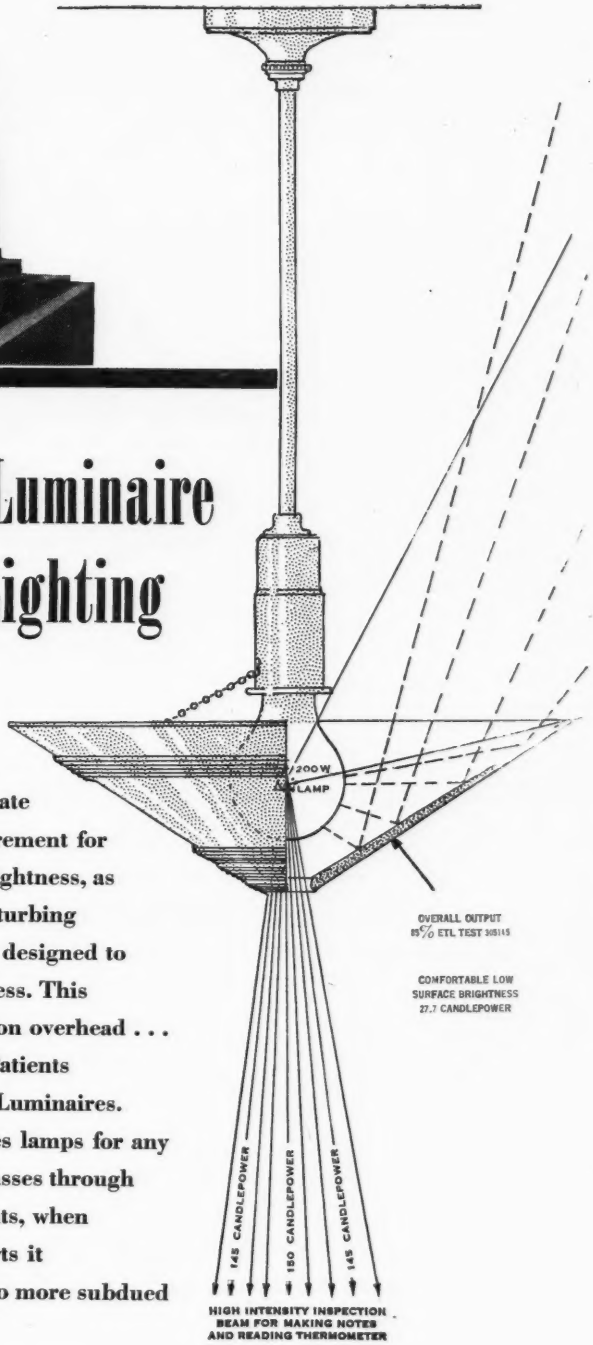

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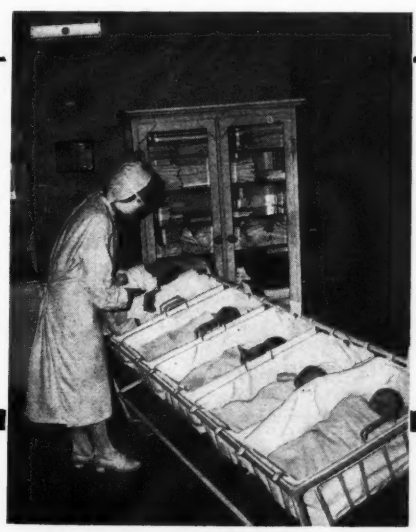

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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, September, 1944 Vol. 21 No. 9

Safeguarding

Nurses and Personnel In Sanatoria

By E. L. ROSS, M.D.,

Medical Superintendent, Ninette Sanatorium, Ninette, Man.

THE logical approach to our present day understanding of tuberculosis and the specific problem under consideration to-day takes us back over sixty years. Until then man's efforts to control the white plague had been characterized through 5,000 years of recorded history by confusion and indecision, by following will-of-the-wisps and hereditary diatheses. The dawn of intelligent effort to cope with the inveterate foe tuberculosis was Koch's discovery of the tubercle bacillus in 1882.

Following in quick succession upon many centuries of surmise and error we come to two periods. The first of these periods we call the "sanitorium era" of anti-tuberculosis work, extending from 1882 to 1924, because the sanatorium and the sanatorium alone constituted our one and only form of organized attack. In the second period of twenty years *preventive measures* have come to the fore and it is now realized that the goal of eradiction can only be achieved by prevention. Even thirty years after the infectivity of tuberculosis had been proven, infection was still universal, and since everyone seemed to be infected anyway the main efforts were turned towards building up of resistance and attempting to cure those who broke down. As a result of improved living conditions, isolation and treatment in sanatorium and earlier diagnosis, we awoke to the fact that tuberculosis was no longer a universal infection, and awoke to the possibility of its complete control—an essentially new viewpoint that enhanced the whole plan of attack. The emphasis on prevention does not detract from the role of the sanatorium, because the foundation of an anti-tuberculosis campaign is adequate beds and treatment.

Dr. E. L. Ross.

Safeguarding Personnel

The question of safeguarding personnel arose even before the infectivity of tuberculosis was shown by the researches of Koch. There were

Ninette Sanatorium from the Lake.

strict laws directed most vigorously towards the personal effects and surroundings of persons dead of the disease. Clothes had to be burned, dishes and utensils destroyed and even buildings burned—with the result that the contagious theory of tuberculosis was not a popular one.

The discovery of the tubercle bacillus led at once to the tightening of rules and regulations respecting the safeguarding of personnel and, since the sanatorium method of treatment was the only one carried on in an organized way, these rules applied to the personnel of sanatoria almost exclusively. These were rules respecting the disposal of infected body secretions, personal hygiene and conduct and the social inter-relationship of patients and attendants. The result was that personnel within a sanatorium were safer than the person out in the community, where those at large with unknown tuberculosis carried on their regular mode of life, scattering tubercle bacilli far and wide.

Nearly everyone reacted to tuberculin and it was considered that repeated small doses of tubercle bacilli conferred an immunity to the disease. The course of events would seem to substantiate this.

The success of the anti-tuberculosis campaign, and especially its preventive phase, has resulted in almost miraculous lessening of the number of infective cases at large in the community; this has resulted in the younger generation being practically not infected at all. Thirty years ago 75 per cent of the population were infected; now only 5, 10 or 20 per cent of children and young adults. Thirty years ago obviously more nurses and hospital attendants must have been infected with the tubercle bacillus than today, yet fewer broke down with the disease. Today there is a greater attempt than ever before to protect the nurse.

The disease tuberculosis cannot develop without infection with the tubercle bacillus. During this earlier era many more than now contracted the disease and died of it, but those who survived received smaller doses of infection that did not produce illness. It was from these who had acquired protective immunity that we drew our sanatorium personnel. It is not the purpose of this paper to discuss the place of B.C.G. as a substitute for the immunity conferred to the survivors of universal infection, but, as a result of Dr. R. G. Ferguson's work and the foregoing reasoning, I am in favour of the use of B.C.G., particularly for those who are engaged in caring for the sick. I appreciate the fact that B.C.G. does not provide absolute immunity and that none of the protective measures now carried out should be slackened.

Types of Personnel

Personnel can be divided into three groups: (a) nurses; (b) nurses' assistants or "attendants" and (c) ward maids, kitchen maids, cleaners and orderlies. Dining room, office and maintenance staff do not need to be discussed, as they do not have direct contact with the tubercle bacillus. Records show that they do not acquire infection or break down with disease beyond the ordinary rate for the persons at large in the community.

(a) *Nurses* come to the sanatorium (when nowadays they can be induced to come at all) with meagre knowledge of tuberculosis and protective measures in the handling of cases. "Knowledge is Power" was never truer than in this respect for, with little knowledge of the disease, it is not to be wondered at that only one-quarter of them are willing to consider doing tuberculosis nursing. No doubt a potent element responsible for the fear of tuberculosis is the "tuberculosis conscious" attitude developed by propaganda among the population in general. This is desirable, and the only way to offset the apprehension of the nurse is the giving of B.C.G. and a regular course of tuberculosis training in affiliated sanatoria after they have received their infectious disease training. It also seems necessary throughout the training of the nurse to instil more emphatically the obligation to meet the call of duty that rests on her as a graduate nurse. No doubt the nurse would more readily assume her true role if those responsible for tuberculosis work would demonstrate to her that everything possible is being done to safeguard her in the fulfilling of her duty. In the sanatorium, by instruction and example, a greater consciousness and practice of protection has been developed than ever in the past, but possibly a more interested and intelligent appreciation of protective technique could be attained if the nurse were given an opportunity to learn more about the individual patients she attended.

The shortage of help at the present time makes it exceedingly difficult to undertake any additional duties in

the way of lectures and teaching, yet there is little doubt that in most tuberculosis institutions more along this line should be done.

(b) *Nurses' assistants:* What is true of nurses is doubly true of nurses' assistants who come to sanatoria without any preliminary training.

(c) *Kitchen maids and other ward help:* These constitute the last group and the most difficult to safeguard. They are a group of varying intellect and variable education and judgment; therefore, their safeguarding must be largely in protective measures to which they are made to adhere rigidly. Staff mingling with patients apart from the strict carrying out of their duty is a source of infection; discipline to control this and the providing of other avenues of social entertainment are essential.

Study Findings

Fifteen years ago I made a study of tuberculosis in 60 nurses who had been admitted as patients to the sanatorium during the previous five years. They had all come from general hospitals. At one particular time 12 per per cent of all female patients were nurses, and it was estimated that during this period of five years 6 per cent of the nurses trained and graduated in Manitoba became sanatorium patients direct from their training schools or within a year of leaving them. I stated then that "It is very rare to have a sanatorium nurse break down with tuberculosis." Some reasons for this are: the work on the whole is less strenuous; routine and energy expenditure, apart from nursing duties, is usually of a quieter variety; all patients are known to be tuberculous and considered infective; proper precautions about cough and the disposal of expectoration and discharges are carried out, and it is also considered that by repeated small doses of tuberculosis infection some immunity is established. Unfortunately, no record was made for this period 15 to 20 years ago of sanatorium personnel who developed tuberculosis.

Since 1938 tuberculin tests have been done routinely, chest films have been more regular and health records kept better for sanatorium staff. At present a study of staff employed at Manitoba Sanatorium during the six-year period from 1938 to 1943 inclusive is being carried out. Impressions are often misleading, and I was surprised to find the number who had developed some manifestation of tuberculosis.

During the past six years 558 persons have been employed at the Sanatorium. Of these 223 or 40 per cent had a negative tuberculin test when they entered service, and 75, or 33 per cent, of these negative reactors became positive. Altogether 13, or 2.3 per cent of the total number developed some evidence of tuberculosis. Forty per cent with a negative tuberculin might be considered low, but it must be kept in mind that insofar as possible an attempt was made to accept only those who reacted.

Of the 13 who developed tuberculosis, there was only one graduate nurse; eight were nurses' assistants without any previous hospital training, and four were maids or cleaners on the wards. From this experience it would still seem to hold that *the Sanatorium is a safe place for the Trained nurse, but less so for untrained personnel.* The average age of breakdown was 25 years. I thought it might have been lower. There was one girl of 18, the rest were in their 20's, except for one aged 36.

Of the 13 breakdowns, nine had a negative tuberculin test and four were positive at the beginning of their service. The nine who became positive did so within an average of four months of coming to sanatorium. In five of the nine a lesion was discovered at the time the tuberculin test was first positive and in the other four the average interval between the positive tuberculin and manifestation of dis-

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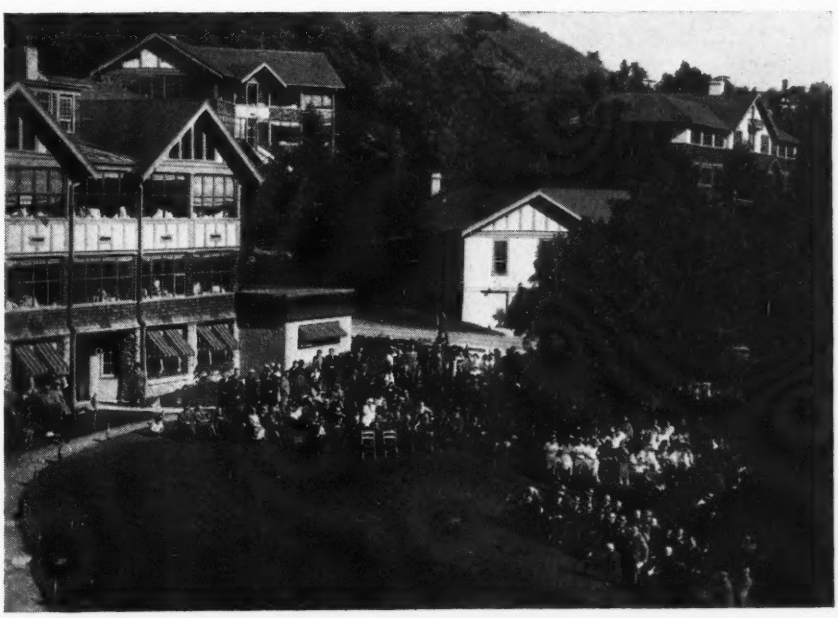


A Special Event at Ninette.

Special Training Needed for SANATORIUM NURSING

By MISS EDITH STOCKER,

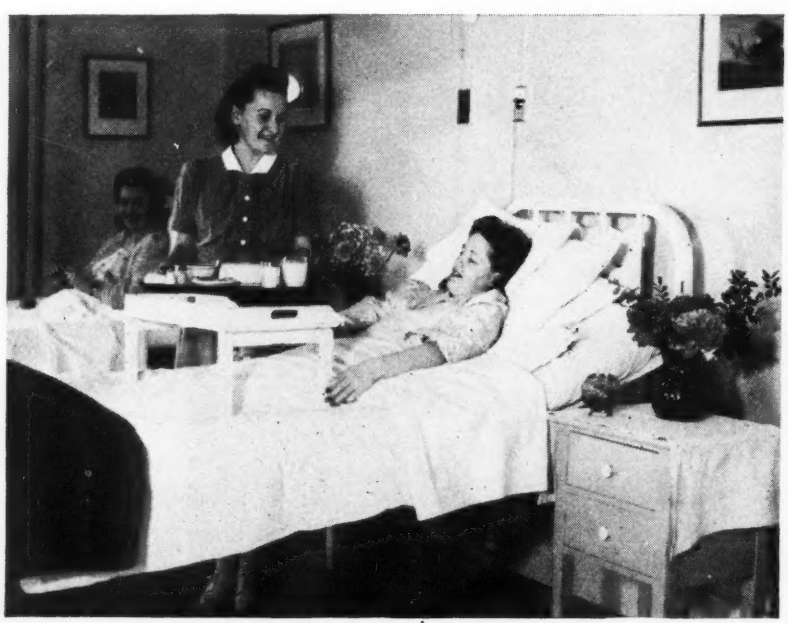
Director of Nursing, Manitoba Sanatorium, Ninette, Manitoba

WE find the present day sanatorium for tuberculosis is a hospital where modern and progressive scientific treatment is being carried on; but we do not in many instances find there, nurses who have had any special preparation in the field of tuberculosis nursing prior to coming on the staff. They may have had a few lectures in tuberculosis during their training period, but they lack clinical experience; in fact they often are very hazy about the tuberculosis programme as a whole. It is evident that the higher standards which are necessary to meet the nursing requirements of the present-day management of tuberculosis call for (a) more and better *instruction;* (b) greater *clinical experience* for the student nurse, and also (c) special post-graduate work for the institutional nurse and the public health nurse.

At the present time we are feeling this lack of preparation on the part of the nurse more keenly than ever, in view of the fact that we have to draw our staff from whatever sources are available—regardless of qualifications in this clinical specialty. The nurse who has not been prepared and educated in the tuberculosis programme in its entirety cannot be an educator herself. The result is that the education of the nursing staff personnel is not being adequately carried out—partly because the few nurses obtainable in these times have not had sufficient preparation themselves. We must engage too many aides in proportion to the number of registered nurses obtainable in order to carry on. While many of these aides do excellent work and can give the necessary bedside care to certain types of patients, they do require very close supervision in regard to technique, particularly in protecting themselves. We have not sufficient staff to give this supervision.

It would seem that the earlier the nurses have training in this clinical specialty, the better; student affiliation, probably in the third year of training, would seem advisable. Students are readily impressed as a rule and make excellent teachers themselves if they are encouraged to do so.

We need nurses in our sanatoria trained to be thoroughly conscientious in the carrying out of aseptic technique and with a thorough knowledge of health hygiene. We require nurses to care for our patients who are familiar with tuberculosis from all angles—who have a good understanding and working knowledge of the modern scientific treatments, the nursing care, the sociological and public health viewpoints, rehabilitation programme and the preventive programme. We need staff nurses qualified to teach—to be educators; nurses who know *more* than good bedside nursing are required. The average patient is a fairly intellectual person who learns a great deal about his disease and finds out all he can about tuberculosis. The nurse who cares for him should be as many steps as possible ahead of the patient in this respect.



The care of the tuberculosis patients is a nursing problem. We have to face this fact and instil it into the students in schools of nursing. On the other hand, sanatoria must be prepared to give these students, if they affiliate, the fullest educational programme possible. Most of the schools of nursing in Canada include a series of lectures in tuberculosis in their curricula, and some include affiliation. Could not a modern tuberculosis unit be used as a substitute, or to augment the desired experience in acute communicable diseases? Both have several objectives in common; both are branches of preventive medicine, focussed on public health and both use an aseptic technique, though the technique in tuberculosis must neces-

(Concluded on next page)

The PUBLIC HEALTH NURSE —*and Tuberculosis*

By MISS ELIZABETH RUSSELL, Reg.N.,

Provincial Department of Health, Winnipeg, Manitoba.

OUR tuberculosis nursing programme has not met the community need. Why? The reasons include: the limited number of provincial public health nurses, the lack of field supervisors, the extent of the area that had to be served by one nurse, poor roads, lack of transportation, the restricted health and social resources of the community, and the fact that, at most, not more than two visits could be made to a home in one year.

But one wonders also how much our programme has been hampered by the inadequacy of the nurse. It has been assumed in the past that a nurse graduating from a recognized school of nursing was competent to nurse all diseases and disabilities, and also give the necessary teaching re prevention and control.

What have we a right to expect of the public health nurse in tuberculosis nursing that she should be prepared by training and experience to give?

The public health nurse must be a teacher in all her home visits. Therefore, she needs a knowledge not only of disease, but of the application of that knowledge in controlling the spread, preventing infection and facilitating the cure.

She needs to have experience in caring for tuberculosis patients if she is to know the meaning of what is learned in the classroom about tuberculosis. She must know the importance of proper diagnostic facilities; she must have seen these facilities used and know how available they are to the people of Manitoba. She must know how to protect the family if the patient is at home. She needs to learn how to protect herself.

She needs accurate, sound, and up-to-date information to enable a patient and a family to follow an acceptable routine, to prepare patient for entrance to a sanatorium or return home. She must know the treatment required and used, and must have worked with patients undergoing treatment in order to interpret the effect of such care to patients and families. She needs to develop attitudes at least as sound as those which patients and their families have developed.

Only by caring for tuberculosis patients can the nurse develop an understanding of the meaning of rest. In this phase of nursing the patient as an individual and as a member of a family and of the community, must be considered.

In a long term illness, communicable in nature, the nurse must learn more of mental hygiene, and use this to advantage in her care of patients.

She must learn to understand and care for the whole patient. She needs to allow the patient independence so that he will not retrogress too far during his incapacity. Preparation for useful work is essential, and education of the patient all through his stay in sanatorium is carried out. This experience gives the nurse a viewpoint and insight which is indispensable if she is to perform public nursing in the generalized field.

It is essential that the nurse be well prepared to meet this demand for more and better health service.

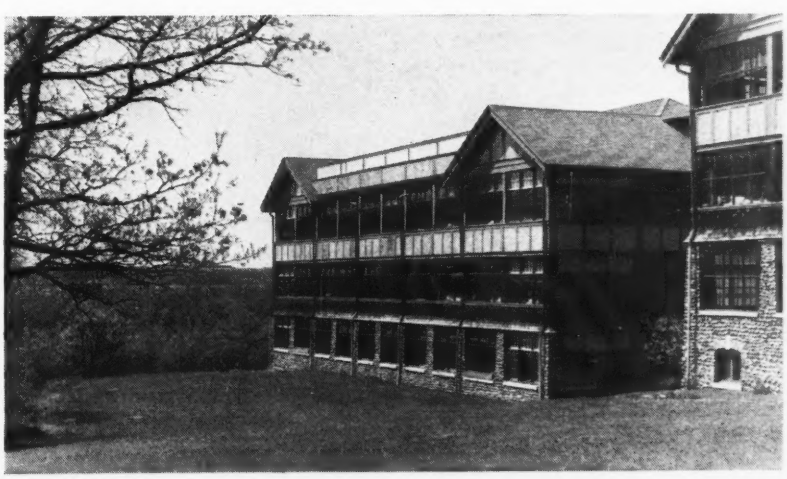
Special Training Needed

(Concluded from previous page)

sarily be modified; both have the sociological and public health viewpoints.

We need nurses in sanatoria who are "public health minded". With the prevention of disease coming ever more to the fore, is it not absolutely imperative that nurses be especially trained in a disease which is so vitally a problem in our community?

Nurses often refuse to come to sanatoria. Why? While in many cases the nurse herself, or a member of her family is against her nursing tuberculosis patients, in a large number of cases it is because the nurse herself has had no special preparation in the field of tuberculosis nursing. In a number of schools of nursing in New York City tuberculosis affiliation is compulsory, which would imply that these schools have broadened this service, not as a specialty, but as an integral part of their structure.



West Infirmary, Manitoba Sanatorium.

November 11, 1918.

How Will You Maintain Services on V-DAY?

ONE of these days the radio will suddenly announce that the Boche "supermen" have capitulated. At the rate the United Nations are now advancing, that day may not be far off—actually it may come with dramatic suddenness and with practically no warning.

How will your hospital be manned that day? Will most of your staff join the hysterically happy throng that will down tools everywhere and jam the main thoroughfares in a wild frenzy of delirious relief? Will there be anyone left on duty to run the elevators, to answer signal lights, or to keep up steam?

Do you remember November 11th, 1918? Throngs everywhere; the last workman off duty tied down the shrieking steam whistle and joined everybody else on the street; all street cars abandoned; crawling motor cars buried under a dozen or more hitchhikers—on the roof, the bumpers and every other inch of space; planes skimming the roofs and doing loops over the treetops. Undoubtedly it will happen again.

Our hospitals cannot close down. Crowded to the doors, the services must go on, come what may. There will likely be a crop of accidents that day, too, and the emergency wards will be busy. Have the hospitals made plans for maintaining their services on that day?

Obviously the final factor will be the attitude of the employees themselves. Naturally they will want to celebrate like everyone else and it will not be easy to stay on duty with so many others enjoying themselves outside. Feeling that most employees can be depended upon to face up to their responsibilities if the importance of so doing be brought to their attention in advance, the superintendent of one hospital has addressed a letter to his employees asking for their full co-operation in meeting this serious situation:

Letter to Staff

"To all Members of the Staff:

It would appear from news which is coming through daily from the European theatre of war that there is a very definite possibility that hostilities may cease sooner than we may have anticipated. We realize that the end may come very suddenly and we will have no early advice until hostilities actually cease. This means that the reaction and feeling of relief will be such that there will be a very understandable desire on the part of everyone to have some part in any celebration which may be carried on in the city at that time.

"This may readily create something of a difficult situation, as hospitals are not in the position of stores or factories that can close down. We have a very definite duty to perform in seeing that the sick and injured in the hospitals are not left with inadequate service. With this in mind, I would ask that no member of the staff leave a service uncovered or fail to report for duty without arrangements having been made with the head of that particular service. We, on our part, will make every effort to see that all members of the staff have certain time off to participate in any celebration. We do, however, want to make sure that the necessary arrangements have been made to cover all the services. We appreciate to the utmost the way the staff has carried on during these very trying times, thus enabling us to provide all essential services to the patients. We would ask your continued co-operation."

Fifty Years of Progress

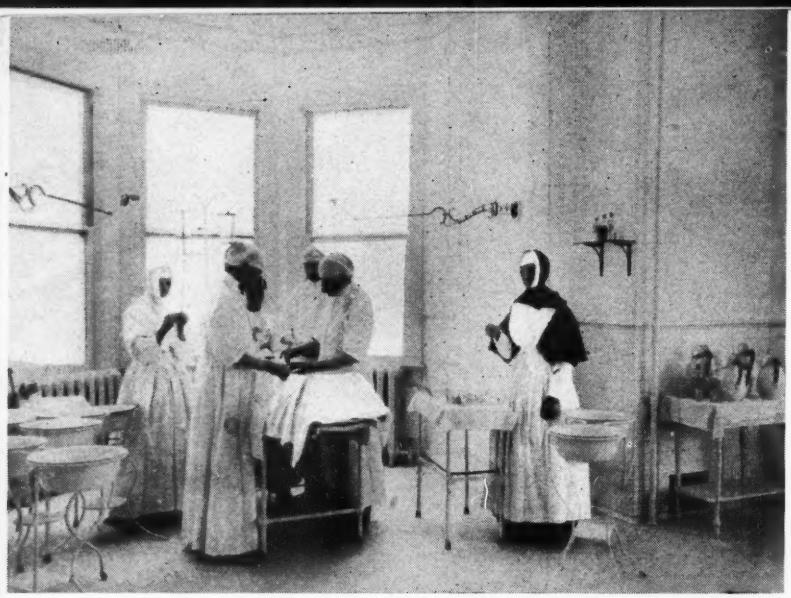
St. Paul's Hospital, Vancouver, Observes Golden Jubilee

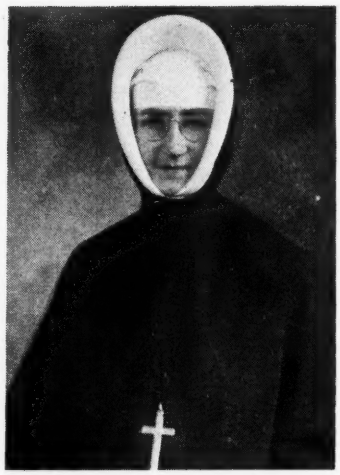
THE year 1944 marks the Golden Jubilee of St. Paul's Hospital at Vancouver. It was in 1892 that, recognizing the need for increased hospital facilities in the rapidly-growing city, the Sisters of Charity of Providence came to Vancouver and purchased seven lots of land on which to build a small hospital.

The original building stood on the site of the present South Wing, a location which at that time was almost isolated from the business centre of the town. It was a wooden structure of four storeys, with accommodation for twenty-five patients in public, semi-private or private wards. The spacious grounds

Above: The hospital in 1894.

Left: The main entrance to the Hospital.





Rev. Sister M. Philippe, Superior of the hospital.

Above: A surgical operating room, 1912.

Left: The first graduating class from the School of Nursing, 1910.

Mother Anne Philomena, Provincial Superior.

Rev. Sister Kolumkille, head of the School of Nursing.

and orchards proved ideal for convalescent patients. The staff consisted of seven Sisters. The first patient was admitted on November 21st, 1894.

The hospital prospered under wise guidance, and it soon became evident that more beds were needed to accommodate the increasing patients. Accordingly an extension was built in 1904, which increased the bed capacity to 75. A couple of years later the first x-ray equipment was installed, along with apparatus for electric therapy. It is noteworthy also that the hospital was just a little over ten years old when the first Ladies' Auxiliary was inaugurated by Mrs. F. X. Martin. In 1907 a training school for nurses was opened with 14 students enrolling in the first class.

During this period Vancouver continued to grow at a prodigious rate

Right: The Chapel.

and its needs far surpassed the available hospital capacity. Plans were therefore laid for a much more ambitious structure, of which the cornerstone was laid in August of 1912. The new building was an up-to-date fireproof construction of reinforced concrete with terra cotta trimmings and pressed brick granite base. It was five storeys high with basement and attic. The newest appliances were installed in connection with heating, ventilating and signal systems. With a staff of twenty-six Sisters, fifty-two nurses, two interns and twenty-four employees, the new hospital cared for 2,350 patients by midsummer of the first year.

By this time St. Paul's Hospital held an established place in Vancouver medicine, and as the years went by the Sisters were put to various shifts to increase the bed capacity of the institution. Departments were re-organized, the first floor of the original building was adapted for the re-admission of patients, an infirmary for infants was added to the nursery and provision made for isolation cases.

An ambitious building programme undertaken early in 1930 culminated in the opening in 1931 of a new nurses' home and an additional hospital unit, the North Wing.

The North Wing has accommodation for 150 patients and, like the nurses' home, is built of reinforced concrete faced with red brick. Here are concentrated the surgeries, of which there are thirteen, sterilizing rooms, doctors' quarters, etc.

The final addition, the South Wing, was formally opened in June, 1940. The new building is almost the replica of the North Wing in design and architecture. It has a bed capacity of 216, including 60 beds in the paediatric department, which occupies the entire third floor. A feature of the building is the two cheery roof-gardens to which an elevator leads directly from each department, so that beds may be wheeled out easily.

During the war years an added strain has been put upon the hospital. In 1941 and 1942, when invasion from the Pacific seemed inevitable, the hospital co-operated whole-heartedly with the C.D.C. authorities in preparation for any conceivable emergency. It is interesting to note, for instance, that the first blood-bank in British Columbia was opened at St. Paul's, with a long list of voluntary donors. Throughout the years the hospital has kept pace with community needs and with the ever-rising standards of good hospital service. It is a far cry from the little wooden building with its one major and one minor operating room to the present extensive structure with its diverse equipment and facilities, its cafeterias and laboratories, its solariums and laundries. St. Paul's has matched medical progress, step for step.

One of the Operating Rooms.

New Addition to Winnipeg General Hospital

A $15,000 addition to the west wing of the Winnipeg General Hospital will be ready for use this month. On ground floor will be a coffee room for doctors and internes and on the floor above a dressing room for private duty nurses. On the operating floor will be a dressing room for nurses and women doctors, a nurses' office and a waiting room. The addition was donated by Mr. J. T. Boyd, member of the hospital board.

Personnel Management

Ideas Gleaned at the A.H.A. Institute On Hospital Personnel Management

By ARTHUR W. SMITH,

Assistant Superintendent,
Royal Victoria Hospital, Montreal

THE Committee on Personnel Relations and Council on Administrative Practice of the American Hospital Association deserve high praise for their efforts in making the First Institute on Hospital Personnel Management at New Haven in June such a success.

The members of the committee responsible for choosing the speakers should be commended as each one was outstanding and left much food for thought. Some of these ideas are set forth in the following paragraphs.

The Personnel Manager

Personnel management has a definite part to play in our hospital set-up today, and this should be delegated to someone, no matter what size the hospital may be. In smaller institutions this work may be combined with the responsibility of the office manager, accountant, housekeeper, dietitian, etc. The larger organizations could well afford to have one person in complete charge of all personnel and their records.

The president of the board of governors or the hospital administrator may say, "Why do we need someone trained in personnel management? We are getting along without anyone now; that sort of set-up is all right for industry, but not hospitals". This is not so. The industrial problem is entirely the same as in hospitals today. Their problems may be large but the fundamental principles are the same. Personnel policies, selection of the employee, medical examination, employment records, safety measures, system of promotion, salary schedules, termination of employment, pension schemes are the hospital's every-day problem, the same as industry.

Let us, for the sake of argument, decide the hospital is large enough to have its own personnel manager, and the administrator wishes to sell the idea to his board. What are the outstanding points?

1. *Improved Organization*: A definite employment policy ensures more satisfactory employees.

2. *Standardization of Records*: Facilitates the setting up of a modern system which could cover the employee from the time he enters the institution until the date of his separation.

3. *Centralization of Employment*: A single channel for the employee to pass through from the time of his selection on.

4. *Improved Hospital Care*: This will be ensured by having the right employees because of proper selection by someone trained in selection.

5. *Increase Income and Decrease Expense*: Labour turn-over can be kept to a minimum. The employee's peace of mind and love for his work sells future hospital service.

6. *Protection of Hospital Property and Equipment*: Each employee can be given instruction in the value of plant equipment; he can be instructed how to care for such equipment and the part it plays in the hospital's daily routine.

7. *Time Saving for Department Heads*: Only one person is responsible for employment—departmental heads have more time for their immediate problems.

Having sold the board of governors the idea of a personnel department, our attention is now turned to the place of the personnel manager and his relation to other department heads. As the policies of the organization are formulated by the board and the administrator, it is only right to assume that the personnel manager should be responsible directly to the administration. The personnel policies should be clearly defined and workable to the general satisfaction of all the employees, which will lead to a smoothly working organization.

Qualifications Necessary

Experience in some other position. Does not need to be at present employed in a hospital.

High sense of social value.

Good general intelligence.

Courage and determination.

Sense of humour.

Willingness to learn.

The personnel manager is really a purchasing agent and a salesman. He must know what he wants and the source. He must be able to sell the prospective employee the position, and at the same time leave the applicant with a feeling of pride that he has decided to work for the hospital.

There must be a friendly working spirit between the personnel department and other departments. Even though the applicant has been interviewed and selected for a certain position, the final approval must come from the departmental head where the prospective employee will work. Should this person not be satisfactory, he should be returned to

the personnel department where another position might appeal to the applicant.

The department head should feel free and willing to discuss departmental problems and requirements at all times with the personnel staff. There must be 100 per cent co-operation.

Selection of Employee

Employee must be made to feel at ease during the interview.

Have the applicant's interest throughout the whole interview.

Don't be easily satisfied.

Know the analysis of the job you are selling.

Consider the whole person.

Greet the applicant—you start the conversation.

Take notes during the interview.

High scholastic marks do not always mean the best employee.

Note general appearance and character.

Make a practical selection.

What were the post-interview reactions?

In cases where it is difficult to select, it may be well worth while to interview another member of the family.

Every new employee should be informed of the working conditions of the position he is taking, as well as the general employment policies of the hospital. These could all be covered in an employment manual, but should one not be set up, they should be explained in the final interview.

Factors in Working Conditions

Hours, maximum, minimum, total number per day, hour spread.
Days off per week.
Rest periods during working day.
Vacations.
Statutory holidays.
Sick leave.
Health services.
Benefit plans.
Leaves of absence.
Military service.
Labour relations.
Wages, maximum, minimum, method of payment, frequency of payment, tax deductions, and overtime rates.
Meals.
Laundry.
Uniforms, number issued, care of wearing on streets, etc.
Elevator service for employees.
Selective Service requirements.

A Royal Board President

On her eighteenth birthday, Princess Elizabeth took over her first public appointment when she was elected President of the Queen Elizabeth Hospital for Children at Bethnal Green. On her right is Brig.-Gen. Sir Hillchild, B.A., chairman of the Hospital; on her left is the retiring President, Rt. Hon. Lord Iliffe, C.B.E.

Courtesy Hospital and Nursing Home Management.

Describe the job to be done fully.
Physical demands of the job.
System of promotion.
Grievance procedure.
Training courses available.
Safety precautions.
Fire alarm system.
Recreational activities.
Termination of services, dismissal—written notice, length of notice to be given.
Amount of pay for immediate dismissal.
Reason for dismissal.
Resignation — length of notice required, terminal interview.

Every employee is entitled to good leadership, and it is the responsibility of the administrator to see that there is such, and that it is carried out to the general saisfaction of the employees.

There must also be mutual responsibility between the employee and employer for good results to be obtained. The employer cannot expect any employee to accomplish his requirements if he is not supplied with proper tools, safe working conditions, properly lighted and ventilated living quarters and adequate remuneration. Where the employer plays the game squarely with his employee, it is the solemn obligation of the employee to do his work, or expect lack of recognition when promotions are in the making.

The personnel manager should arrange for hospital tours so that all new employees may familiarize themselves with the general lay-out of the buildings. This saves time, money and energy. While making rounds the care of the plant and equipment should be stressed and the "do's" and "dont's" explained. The most important thing to point out to any new employee is the relationship of his, or her, work to the finished product—hospital service.

Job Analysis

In setting up a personnel department, it is desirable to have a job analysis for each employee and then finally set out job specifications for them. This takes a great deal of time but it pays dividends. Suppose we take the main kitchen in any hospital; job specifications can be set up for each person from the pot washer to the chef. This would show the kind of work performed, time schedule of duties, responsibility he may have for care of equipment, days off per week, who is his relief and whom he relieves. This information can be kept on 3 x 5, 4 x 6, or 5 x 8 inch cards, and in the same size files. Metal signals for days off, holidays and relief could be used.

The dietitian could have a duplicate set of these files for her office.

(Continued on page 78)

Obiter Dicta

Division vs. Unity

WHAT progress are we making in the development of unified health plans? Are we amalgamating and consolidating the plans with small or restricted membership into broader plans serving large areas and all groups of citizens, or are we tending to break up into sectional units? Both influences seem to be at work. On the one hand we see our leading Blue Cross plans in Canada and the United States covering larger areas and replacing many of the one-hospital or one-industry plans in their territory. We see these plans extending into rural areas to provide badly-needed coverage to non-industrial groups, and we see many signs of closer co-operation between these large provincial and state plans. Actual amalgamation may be an early possibility in many cases.

On the other hand, there is a noticeable tendency for certain groups, stimulated by the success of the Blue Cross plans, to launch their own plans. Perhaps the most outstanding example on this continent is the proposal of the United Auto Workers (C.I.O.) in Michigan to set up their own medical and hospitalization scheme and drop out of the Michigan hospital and medical plans. As this body represents a potential membership of one and a half million people, the effect of such action on the recognized hospital and medical plans is obvious. In Ontario a number of the credit unions buy their hospital service from the Plan for Hospital Care, but the setting up of CUMBA (see p. 68) indicates a desire on the part of some to operate their own plan, and we believe that one or two of the co-operatives are thinking of a similar action. In British Columbia there is a somewhat similar situation.

This tendency is not wholesome. Carried to its ultimate outcome, there would be a plethora of separate bodies giving varying degrees of service and with varying degrees of oversight in the segregation of funds which should be reserved for health care. Large groups of the people would be excluded from these plans restricted to special groups. Right now, with a high degree of national health, good surpluses are being developed, and this may be a factor in stimulating organizations to set up hospital and medical plans of their own. In times of epidemic or widespread illness, however, many of the plans with limited reserves or erected on an actuarially unsound basis might find themselves quite unable to weather the storm—a serious matter for both patient and hospital. Hospitals (or the medical profession in the case of medical plans) seldom have any voice in the operation of private plans, where the natural tendency is to shop for low costs rather than quality of service and to adopt a dictatorial policy of "or else".

Many of these comments, of course, may not apply to the cases cited, but, before signing contracts, both the hospitals and prospective members would be well advised to check carefully the ability of any plan to discharge its obligations. If our voluntary plans result in confusion and dissatisfaction rather than co-ordination, the net result will be state intervention.

A Factor in Releasing Beds

ELSEWHERE in this issue we quote the report of the Advisory Committee on Hospitalization and Public Welfare of the City of Toronto. This report, signed by A. W. Laver, Welfare Commissioner of the city, is the outcome of the desire on the part of city officials to have some clear-cut policy with respect to the provision of funds for hospital construction. Undoubtedly this situation exists in other cities, due to a tendency for each institution to develop more or less independently of the others. There has been a feeling for some time that some co-ordination of policy involving all hospitals would lead to more efficient results and would prevent a certain amount of overlapping or the omission of certain important types of service.

This necessity was recognized by the Canadian Hospital Council in its recommendations in connection with the National Health Survey a year ago, at which time it was recommended that a province-wide committee or commission study the hospital needs and work out some co-ordinated policy which would be fair to all groups concerned. The suggestion in Toronto that funds for construction be provided, 1/3 by the hospital board; 1/3 by the province and 1/3 by the municipalities benefiting by such hospital, is a reasonable suggestion and has features very similar to the basic policy followed in Quebec Province with respect to the care of indigents. From the point of view of the hospital, one difficulty will be to obtain the 1/3 to come from the municipalities. The problem will not be so much with the municipality in which the hospital is located, but with the neighbouring municipalities, which are seldom sufficiently hospital-conscious to express their appreciation of hospital facilities in a tangible way.

The emphasis upon immediate provision of facilities for the chronically-ill is most commendable. As the Committee points out, 100 incurable patients would occupy beds in general hospitals for 36,500 hospital days. In the same year, based on 15 days average stay, 2,433 acutely-ill patients could be accommodated in these 100 beds. As the average stay of non-chronic patients is less than 15 days, the number who could otherwise be accommodated would be still greater.

At the same time it is hard to understand why this Committee, which is rightly concerned over the inability of acutely-ill patients to find accommodation in general hospitals because of the presence of chronic patients, should prefer not to make any recommendation for the extension of convalescent facilities. After approving the giving of large sums of money to other hospitals, the Committee turned down the request of the overcrowded St. John's Convalescent Hospital for assistance, for "your Committee is not convinced that this additional accommodation is necessary at present for this type of care".

This regrettable recommendation may be due to a misunderstanding of the proper utilization of convalescent hospitals, or of the modern meaning of that term. From the point of view of releasing beds in general hospitals, a convalescent hospital for subacute and short-stay convalescent patients is particularly valuable. A bed in a hospital for incurables can take but one patient in the course of a year, but on a basis of two weeks' stay per patient a convalescent bed can take 26 patients in the course of a year. Moreover patients who would go to a convalescent hospital are not those likely to become incurable and therefore a totally different group of patients would be released from general hospitals. Actually the modern convalescent hospital is more of a sub-acute hospital than anything else, and takes patients while still bedridden and requiring a fair amount of nursing care. In Edinburgh, for instance, laparotomy patients are often transferred within 5 or 6 days after their operation. That may be an extreme use, which may not be readily adopted here, but it does indicate the practicability of transferring many sub-acute patients from the more costly institutions. Certainly the long-stay fracture cases which now occupy general hospital beds for many months and cannot be taken by convalescent hospitals because of lack of bed space, could be taken if more accommodation were available. Although this report does not so indicate, there does seem to be a growing recognition of the place of convalescent care in a community and of its value in hastening recovery and in preventing relapses, not to mention the badly-needed release of beds in general hospitals.

Prisoners as Hospital Help

THE Wartime Service Bureau (at Washington) of the American Hospital Association has sent institutional members a bulletin on the employment of prisoners of war. In the United States the Office of the Provost Marshal General of the War Department has announced that non-profit voluntary hospitals may hire prisoners of war as personnel. Unless the hospital is located within one hour's travel from a prison camp, the hospital must house the prisoners. Food is provided by the army, but the hospital may provide the mid-day meal, for which an allowance would be made. The hospital makes a contract with the War Department, paying to the War Department a sum equal to the amount that would be paid to free civilian labour for performing the same work.

If a hospital is located near a prison camp, the smallest unit of prisoners of war that can be contracted for is ten; if more than twenty-five miles distant, two hundred must be contracted for. Where there is daily transportation, this must be furnished by the hospital. Prisoners must be kept under military guard at all times—one guard to ten prisoners. Prisoners may be employed for the preparation of meals, upkeep of buildings and grounds, operation of hospital laundry or janitor work. They may be employed on any similar work where ten or more prisoners can be seen constantly by a guard. Orderly work is forbidden by the Geneva Convention. Only German prisoners of war are available to private employers and, actually, all prisoners in the United States are now engaged in essential military work, in harvesting, or in the processing of food or the production of lumber and pulpwood. Prisoners will not be available to hospitals until after the harvest season, unless substantial numbers of additional prisoners are received from overseas.

While the employment of prisoners has definite drawbacks, it is a possible means of reducing the very serious personnel shortage. With respect to the Canadian situation, we are informed by Lt.-Col. R. S. W. Fordham, Director of Labour Projects, (Prisoners of War) that it is not considered practicable to make German prisoners-of-war available for work in civilian hospitals. At the present time no authority exists to employ them in work of this kind. A factor, too, is the difficulty of maintaining guard over them and of keeping them from mingling with the public.

The Major Needs in

Tuberculosis Nursing

By MISS GERTRUDE HALL, Reg.N.,

Department of Health,
City of Winnipeg

NURSING, because it is a younger profession than either medicine or teaching, is changing more rapidly than either. No longer is it possible for a hospital School of Nursing to rest content with preparing the students to render nursing service for medical, surgical and obstetrical patients. Nursing today includes more—much more—than three basic experiences. The field of public health requires nurses whose basic course has at least included experience in those services which as public health nurses they will be expected to include in their ordinary, everyday programme of work.

A considerable part of tuberculosis control work and case finding is entrusted to the public health nurse as she visits in the home. Criticism of case finding is frequently directed against the generalized nursing programme. It is pointed out that nurses who enter the general field of public health do not have sufficient training in tuberculosis and little, if any, practical experience in dealing with the disease. Tuberculosis is a family disease—the nurse who renders a family health service should be in the best position to combat it. The effectiveness of her work will depend unquestionably upon how well she is able to detect symptoms of the disease and to secure action by the patient when its presence is suspected.

Because so much of her work is in the home, the public health nurse must be constantly ready to enlarge her knowledge of tuberculosis and to improve her methods of teaching. It is important for her to know that infection with tuberculosis at any time during the life span is dangerous. She should know also that primary tuberculosis, formerly called the *childhood type*, can develop in adult life as well as in childhood. In addition she should realize that although primary tuberculosis frequently runs its course without symptoms and that recovery occurs without awareness, fever—especially an irregular fever of 100* or more—failure to gain weight, irritability, langour, early fatique and lack of interest in people and surroundings—are danger signals that warrant prompt and continued medical supervision.

The nurse must be able to explain to the child's parents the significance of a primary infection and its symptoms in such a way as to prevent fear or worry and to enlist their intelligent co-operation in assisting the child through his illness.

With regard to the re-infection type of tuberculosis, formerly called the *adult type*, the nurse needs to know that it commonly develops without symptoms, but that any unexplained loss of weight, pain in the chest, fatigue, loss of appetite, indigestion, cough or hoarseness, expectoration of sputum and haemorrhage must be considered as symptomatic of tuberculosis unless proven otherwise. When the nurse has really learned these facts, she will be able to discuss the disease intelligently and convincingly with the people she meets and in the homes she visits. To-day nurses have less difficulty in securing the examination of contacts. A harder problem is to hold their continued interest in the required period of supervision. For this reason it is advisable for the nurse, particularly in the case of adolescents, to see each contact individually and to explain the reasons for his remaining under supervision, and the importance of his reporting for re-examination at the appointed time. In a recent study of contacts who developed tuberculosis while under the supervision of the New York City Department of Health clinics, it was found that in quite a few instances the contact waited to keep his next appointment in spite of the fact that he developed serious symptoms during the interim. The public health nurses are now making certain that each contact knows the symptoms of tuberculosis and what to do when he experiences any of them.

Miss Gertrude Hall, Reg. N.
Miss Hall has since been appointed Secretary of the Canadian Nurses Association with headquarters at Montreal.

Unwarranted Confidence

Because of the emphasis given to the x-ray in case findings campaigns, it frequently happens that an individual such as a survey case develops a false sense of security from negative x-ray findings. He considers himself immune from tuberculosis from that time on. When the nurse encounters any one with this impression she should try to help him understand that the x-ray constitutes but one part of the whole examination and guarantees only that the person did not have tuberculosis *at the time the x-ray was made.* She

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should encourage this individual to study the disease and to consult his physician regularly.

To sum up, effective nursing supervision of tuberculosis patients and their families requires keen perception, ingenuity, patience and, above all, perhaps, a sympathetic understanding of what this illness means to an individual and family and a wish to be of service. It is not possible to formulate policies by which to govern the home visit in any of its aspects; the approach, content, interview and teaching techniques must be adjustable to the particular situation, and situations and human beings are variable.

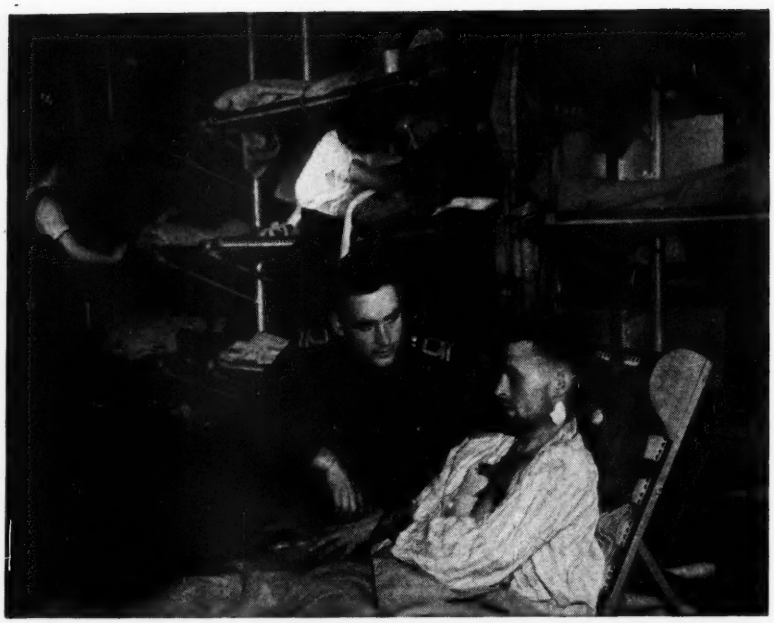
Major Objectives

It does seem helpful, however, to state and thoroughly consider the objectives of the nursing service. The *major objectives* might be listed somewhat as follows:

1. To secure isolation and treatment (medical and nursing) of the active case;
2. To ascertain the source of infection;
3. To teach basic facts about the disease;
4. To teach by demonstration and observation the manual techniques of bodily care of the patient and his physical environment;
5. To supplement and clarify the instructions of the physician;
6. To assist with plans for examination of the contacts;
7. To evaluate and modify, if possible, factors in the physical and social environment which may promote or retard recovery and facilitate or block effective teaching;
8. To assist when necessary with plans for economic welfare;
9. To assist when necessary with plans for rehabilitation of the patient with arrested disease.

The nurse who knows very little about this disease is defeated before she starts because she does not have sufficient knowledge to back up her sales talk; therefore, the patient has little faith in any suggestions offered and does not respond to the appeal.

We would say again that the public health nurse needs and must have the proper understanding of and attitude towards tuberculosis as a health problem and not as something to be shunned as unholy, unclean and untouchable.



Bringing Wounded Back to England

The above picture was taken on board a Royal Navy tank landing ship during an English Channel crossing. It shows Surgeon Lieutenant Charles Robson, R.C.N.V.R., checking up on a patient, Private Frank Sheehy of Sarnia. Surgeon Lieutenant Robson is a son of Dr. Charles W. Robson, anaesthetist to the Toronto Hospital for Sick Children, and is one of many Canadian medical officers serving with the Royal Navy. This photograph by Lieut. R. Arless, R.C.N.V.R., illustrates one of the many considerations that had to be planned for in the invasion of Europe and emphasizes the urgent necessity of supporting the next Victory Loan to the limit.

Safeguarding the Nurse

We turn then to the question which inevitably presents itself. Where and how is the nurse to obtain this experience and how shall her own health be safeguarded? Having read current articles on this subject and studied the suggestions contained in several, I should like to present those which follow for consideration.

The first step in planning must, of necessity, include a thorough study of the safeguards which could be employed in the sanatorium or departments within the hospital where tuberculosis patients are being cared for.

The teaching of patients, supervisory and nursing personnel—and indeed all personnel—is obviously one extremely important step.

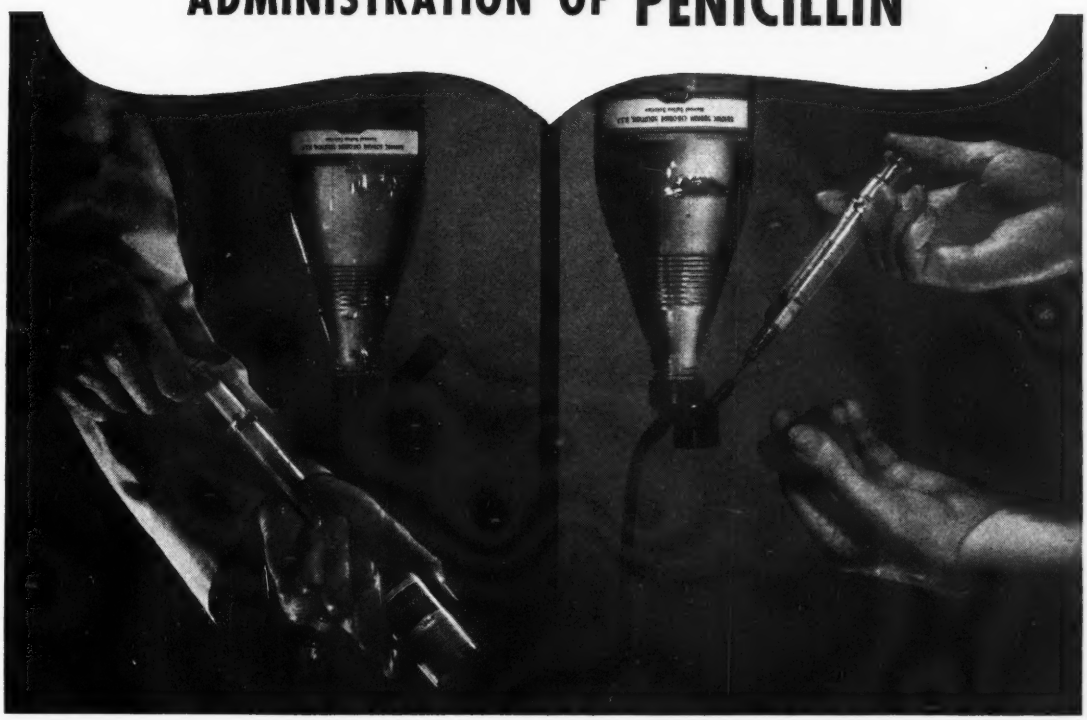
Consideration might be given to re-arrangement of the present set-up within each sanatorium. For example, arranging one infirmary ward where only patients with minimal non-bacillary disease or with more extensive disease controlled by some form of collapse, would be cared for by the students and where they could learn in a reasonably safe environment, routines followed by patients with infectious tuberculosis.

A properly-organized educational programme for students and graduates is vitally needed. The programme should include clinics, demonstration and lectures. The student nurses should be assigned complete case studies which should include all aspects of the patient's welfare as well as those of his immediate family and contacts.

A CONVENIENT AND SIMPLIFIED METHOD

for continuous intravenous drip

ADMINISTRATION OF PENICILLIN



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The Controversy over Beds for War Casualties

What Can We Believe?

By G. H. A.

FOR some weeks back a number of the newspapers of Canada, not to mention members of Parliament, have been battling back and forth over the merits or demerits of the preparations made for the hospitalization of returning casualties, now coming back in increasing numbers and likely to reach a peak within a few months. Height of the controversy seems to be centred about old Christie Street Hospital in Toronto, the cash registry factory hurriedly bought when time was pressing in the last War and still being used and expanded in this War. The fact that some of the government's most severe critics live in that city and control a share of its press has but intensified the controversy.

The public must have been badly confused by the welter of accusations, the conflicting "facts", and the press barrage which at times has seemed to reach a hysterical pitch. From it all has developed a growing fear on the part of many that our returned men are not being properly handled and that provision for their care may really be inadequate.

From the angle of this desk certain observations seem in order:

1. Much of the press criticism of the policy of the D.P.N.H. is largely political, and should be treated as such; nevertheless, many of these statements would seem to have a foundation of truth.

2. The D.P.N.H. has expanded its hospital facilities tremendously during the past few years. The Hon. Mr. Mackenzie stated in the House that the Department now operates 7,519 beds, of which 2,287 were then vacant (August 6). In addition another 1,399 beds could be put up, perhaps squeezed in by erecting temporary beds. On July 22, there were 5,233 patients in Department hospitals and 1,878 in "contract" civilian hospitals. He stated that 20,000 patients could be cared for to the end of the year, although it is difficult to figure this out, unless beds under the Armed Forces be utilized.

3. One is pleased to note that the criticisms have not been directed against the doctors, nurses and other personnel caring for the veterans. Apparently there is general agreement that they are doing a good job, frequently under considerable difficulty.

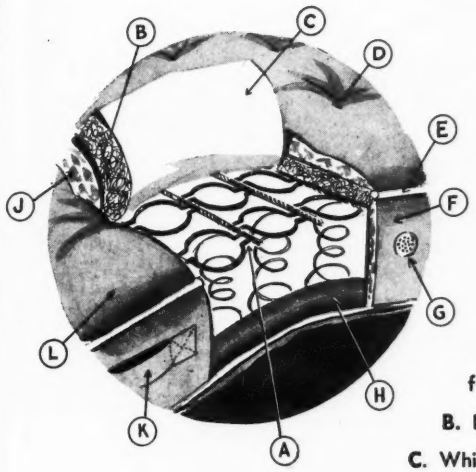
4. The hue and cry against the inadequacy of preparations cannot be dismissed as being entirely political, for it is obvious that conditions at Christie Street, for instance, are far from ideal. The building is old and was never laid out as a hospital. It is right beside the railway tracks, being erected as a factory, with a fairly noisy steel works alongside it. Certain wards are too large, having multiple rows of beds, up to 63 and 82 in number. Ventilation is poor and signal systems are inadequate. For some months back it has been undergoing steady expansion and some remodelling. This would seem obligatory at the present time, for the immediate increasing of bed accommodation is most urgent, but it does seem hard to understand why this building was not replaced years ago. One questions why this replacement was not done during the depression years, as a relief project, or during the early years of this War, when this present situation was so plainly foreseen by so many. Even in 1943 there did not seem to be any alarm at Ottawa (See *The Canadian Hospital,* Feb., 1943, p. 12).

5. From information received from various sources, it is apparent that the other Department hospitals have been crowded also. We take the Minister's word for it that several thousand beds were available a few weeks ago, but apparently this was just after a general "purge", when many patients were sent home rather hastily, we are told, to prepare for expected overseas casualties.

6. The possible reserve of contingency beds in civilian hospitals, which was discussed earlier in the War (see *The Canadian Hospital,* Feb., 1941) might as well be disregarded, for the occupancy of civilian hospitals has risen so high that, coupled with the staffing problem, it would be practically impossible, except under national emergency conditions, for civilian hospitals to care for military casualties. One is sure that they would do what they could, but in all but a few hospitals accommodation could only be provided by closing certain wards to the civilian population now using them.

7. Much criticism has been voiced over the long delay in erecting the big hospital at Sunnybrook, near Toronto, to replace Christie Street. That the buildings were not started years ago is fair criticism, but we cannot share in the criticism that the structure is only being started now, nine months after the decision to build was made. The impatience of the public has been heightened because the sod was turned last November, shortly after the decision to build was made. Obviously the turning of the sod at that time was a political gesture to soothe the ruffled public mind, and was premature. It takes many months to design and work out specifications for a hospital of this size—$2,800,000 for present

Specially Constructed Mattress For Hospital Beds



A world of comfort and durability is built into this mattress . . . specially constructed by Marshall for hospital use. The many outstanding features enable the mattress to bend at will, without distorting the springs or becoming uncomfortable!

NOTE THESE FEATURES:

A. Full offset coil construction made of premier grade wire heat treated. Helical springs running crosswise of the mattress to give hinge effect, thus helping to prevent damage to inner upholstery. Gatch type beds can bend freely without distorting springs.

B. Heavy sisal pad between duck cover and felt padding.

C. White duck insulator covers spring unit.

D. Tape ties, with knots burried for tufting . . . which maintains a constant smooth surface and eliminates buttons turning on edge.

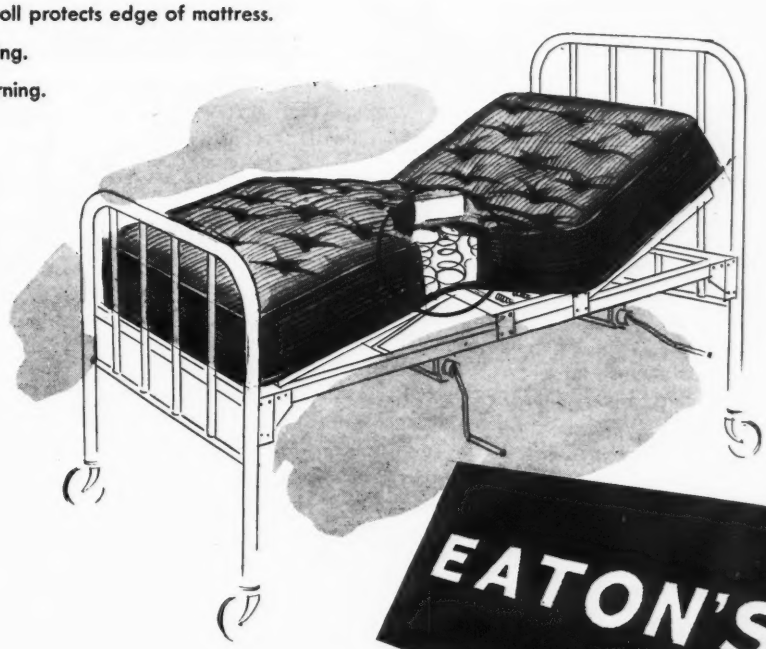
E. Tape bound edges.

F. & G. Prebuilt border with ventilators.

H. Cotton inner roll protects edge of mattress.

J. Soft felt padding.

K. Handles for turning.



EATON'S

CONTRACT SALES DEPARTMENT

construction and up to $10,000,000 ultimately. Precipitous haste at this stage would be foolish. Actually the present construction is for service plant, up-patients, nurses' residence, etc., and will be of but limited material help—except indirectly—for returning casualties for some time to come. One is pleased to note, however, that high priorities have been obtained and quick action promised.

In this connection, however, one would be more optimistic of the early and *full* use of Sunnybrook if there had been more enthusiasm for the project at Ottawa. Christie Street will probably remain the active treatment centre for that area for many years.

We have not been greatly impressed by the reference to the speed of construction across the line. We can learn many things from our neighbors to the South, who have an uncanny knack of getting jobs done while we are still thinking about them—as witness the Alaska Highway. However, in this case, from information available it would appear that the buildings erected are not on the fine scale planned for Sunnybrook, and we have an idea that here, as in so many other instances, speed has been at the expense of economy and perhaps quality.

8. What can be done to utilize for returned cases the many scores of military hospitals across Canada is not clear. As the number of training camps is reduced, many hospitals will become inactive, but most of these are so located that their use for returned casualties will not be practicable.

It is unfortunate that the suggestion of the Canadian Hospital Council in 1941 (see *The Canadian Hospital*, June, 1941, p. 18) that a larger proportion of the government hospitals then being erected be so located with respect to existing civilian hospitals that they could be used for the care of veterans returning from overseas, did not meet with more approval. Since then a few such buildings have been erected (e.g the Pensions wing of the Ottawa Civic Hospital), but had this policy been more generally adopted, more accommodation could now be available and, looking ahead in years to come, there would be fewer abandoned hospital buildings that could have filled an urgent civilian need.

Nursing sisters see one of the German guns knocked out in the first stages of the invasion. Left to right: Lieut. M. Green, Glace Bay, N.S.; Capt. H. M. Boutilier, Sydney, N.S.; and Major (P/M) Moya MacDonald, Halifax.

Canadian Army Overseas Photo.

9. Everybody, irrespective of their attitude in this controversy, will agree with the statement of Dr. H. A. Bruce, M.P., that "What we want is a sufficient number of modern hospitals with adequate equipment and every facility to treat our wounded men when they come home. Anything less than that will not satisfy the Canadian people."

Bed Accommodation Stepped Up by Pensions Department

Announcement has been made by Pensions Minister Ian Mackenzie of the acquisition by his Department of various properties which will be converted into hospitals for returning veterans.

A former men's hostel built for the Department of Munitions and Supply in Peterborough, Ontario, has been taken over and converted into a 350-bed hospital. A similar building in Kingston, Ontario, provides accommodation for 250 patients.

On the west coast it has been announced that the Government is taking over two theological colleges on the University of British Columbia campus for the use of casualties brought back from overseas. Anglican College and 80 per cent of the space available at Union College have been acquired by the Pensions Department.

Mr. Mackenzie also announced that plans are being drawn up for the construction of a 250-bed hospital for veterans in Victoria, B.C. It will likely be built on the grounds of the Royal Jubilee Hospital.

Tenders have been called for the construction of 10 buildings for veterans of this war at Westminster Hospital at London, Ont., at a cost of $300,000.. Eight of the 10 will be single-storey frame pavilions with accommodation for 24 patients.

Pensions Hospitals Get Top Construction Priority

Contractors working on veterans' hospitals are now given top priority on requests for construction workers, it has been announced by Mr. Arthur MacNamara, Director of National Selective Service.

Local office managers have been instructed to keep in touch with contractors and subcontractors doing work on hospitals for veterans, and to supply them with additional labour where needed. If necessary, construction workers may be transferred from their home districts to points where help is needed.

In iron deficiency anaemias

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No.2

Iron in the ferrous state is generally considered as being the most effective form for the treatment of iron-deficiency anaemias. 'Tabloid' brand 'Ferad' No. 2 contains 3 grains of anhydrous ferrous sulphate. The soluble alkali incorporated in the formula performs an important function in counteracting the astringency of the ferrous salt, thus ensuring satisfactory gastric tolerance of large doses.

It is a well-tolerated, effective and economical preparation.

Each sugar-coated product contains
Ferrous Sulphate, Anhydrous, gr. 3
(equivalent to gr. 5½ ferrous sulphate, B.P.)
Sodium Carbonate, Anhydrous, gr. 2

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

A Visit to a Transit Hospital

Dear Mr. Editor:

Three years ago in a description of a Canadian hospital, I wrote (December, 1941) that "as the anticipated invasion had not yet developed, there has not been the opportunity yet to test the organization". The meaning now to be applied to the word "invasion" shows how complete is the change in the whole situation from the time when we were expecting a landing on this island. But the test of the efficiency of the arrangements still remains in the organization. So directly there was news of the arrival of some of the wounded from Normandy I paid a visit to one of our emergency hospitals where Canadians were among them. Was there the necessary co-ordination between the two sets of authorities to secure the prompt and effective treatment for them? That was the key question to determine,—whether red tape had caught up the machinery anywhere. The answer can be given as a confident affirmative without qualification. The hospital where I made inquiries is what is known as a transit hospital where the men arrive in convoys from the detraining centre and remain for only twenty-four hours before passing on to the base hospital. From the English hospital they are conveyed in Canadian ambulances to the Canadian hospital.

The Emergency Service

Some description of this English hospital may be of interest as it has features which are characteristic of the emergency service while others are exceptional. In peacetime it was not a hospital but a school for blind people. On the whole the building has lent itself well to adaptation. The kitchen was inadequate for the much larger number of occupants. Provision is made for seven hundred to one thousand patients with the necessary staff, while before the war there were less than five hundred inmates altogether. The actual needs of hospital work provided greater difficulty. Operating theatres, for example, as your readers will realize, cannot be fitted by magic; and not the least serious item in their equipment is the sterlizing accommodation. So one may go round any hospital and imagine the extent to which an ordinary house would require alteration by conversion of rooms, and provision of entirely new features in a restricted space.

Hutments

Around this main building have been erected hutments which, as I explained previously, are similar to those forming the Canadian Hospital. Thoughtful consideration has placed the Canadian wounded in two of these because the transport was more conveniently situated to them and so the disturbance of removal was reduced to a minimum. All the Canadians were together so that they might have the cheer of comradeship. In the hospital are Canadian trained nurses as well as others who have become Canadian by matrimony.

A Novel Administration

The administration of this hospital is almost unique in the emergency hospital service. It is one of two, and the largest, directly under State Control and managed by a Committee appointed by the Ministry of Health. Thus it is distinguished from hospitals managed either by local or voluntary authorities. In selecting members for the Committee the Minister showed in a practical manner his appreciation of the work of voluntary hospitals by inviting the chairman of one of the London teaching hospitals to nominate three members. This deserves to be remembered when contraversialists are attacking the Ministry for lack of recognition of voluntary hospitals. To these three men are added an official representative of the Ministry and representatives of the medical staff.

The relationship of the medical and lay administration was settled by the appointment of a medical officer in charge and a lay secretary as representative of the managing Committee. For the latter post was selected a woman who had had qualifying experience in voluntary hospitals.

A Feminine Postcript

A woman is generally said to leave the items of news for the postscript to her letters. So perhaps I may follow that example by adding that this hospital stands in an area largely occupied by Canadians. First of all a member of the staff dealing with the medical record was captured, and her voice has already been heard on the Canadian broadcasting system as the first English wife of a man in the Canadian forces to reach Saskatoon. Now the Secretary herself has fallen a victim to another Canadian. Our loss is your gain—that is some consolation.

Plan New Nurses' Home at Fort San

Plans for a $12,000 addition to the nurses' home at the sanatorium at Fort San are under consideration by the Saskatchewan government. The purpose of the addition is to provide living space for 30 student nurses, who will be trained in the care of tubercular patients. Behind the plans for the addition is the idea that the Anti-Tuberculosis Association train its own nurses.

In treating those who recklessly "eat on" extra pounds, the physician may recommend a low calory diet which fails to achieve vitamin balance and thus afflicts the patient with a more serious condition than obesity. While chastening these patients on grapefruit and lettuce, the doctor can supplement their daily diet with Upjohn's small, easy-to-take Unicap* Vitamins and provide an indispensable minimum of protective vitamins without the material addition of calories. Penny-wise Unicap Vitamins, small in size, high in potency, ensure *safe* reducing diets for the pound-foolish.

*Trademark Registered

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Here and There

By the Editor

The Spirit of China

DR. ROBERT McCLURE, well - known Canadian-educated surgeon who has had such a dramatic life in China and who contributed an excellent article to this magazine in June, illustrated the spirit of the Chinese people, in speaking before one capacity audience of business men, by recounting an incident that happened in his ambulance unit shortly before he left China.

Working behind the lines after an engagement between the Chinese and the Japs he noticed a bright young soldier waiting among the wounded patients who seemed to have had a couple of teeth knocked out. He stated that he had had a few teeth loosened and wondered if the doctor could fix him up with a couple of artificial ones. When told that there were others waiting who were more seriously wounded he was quite willing to wait until they could look after him, and made the suggestion that perhaps they might be able, when they got around to him, to put in a couple of gold teeth. "Perhaps", he added, "they would add to my sex appeal".

After everybody else had been looked after, Dr. McClure and his assistant turned to see what they could do about the teeth. When he started to examine the patient Dr. McClure was amazed to find that the whole upper jaw was shattered and that the only thing that could possibly be done would be to remove the entire upper jaw on that side.

"How in the world did this ever happen?" he asked.

"Oh, I just ran into a machine-gun nest and got hit, that's all."

After further examination Dr. McClure said: "I can see how the machine-gun did this to you, but I can't just see how the bullet got in there. Where did it go to?"

Whereup the Chinaman loosened his collar and said: "Oh, you'll find a hole right here at the back," and he pointed to an exit hole almost at the centre of the back of his neck. Fortunately and obviously it had missed vital structures. To the amazed doctor he added that this had taken place two days earlier but he had just got around to seeking medical attention.

It was obvious to the surgeons that the soldier would need to be given an anaesthetic and have a very delicate operation performed. This was explained to the patient and he was asked whether he had ever had an anaesthetic before. Yes, he knew all about anaesthetics —he had run into a machine gun nest once before and had had to have an anaesthetic to get fixed up. He showed a scar where a bullet had gone through his liver and another scar where another bullet had gone through his lung. He then added: "If you have to give me an anaesthetic you might as well fix up this wound also," and he opened up his tunic and shirt a little more and revealed a blood-stained hole under his left collar-bone where a bullet had crashed through his chest, missing the subclavian artery by not more than half an inch.

He was placed on the operating table and in due course, after a delicate operation on his mouth and the cleaning up of the bullet wound, he was returned to the temporary ward in connection with this mobile ambulance. Next morning Dr. McClure made his rounds to check up on the patients and noted that this patient's bed was empty. He asked the next patient where this particular man was. "Why, he left at daybreak this morning. He said he couldn't stay any longer, he had to get back to his unit to help defeat the Japs!"

* * *

Good for Man or Beast

The famous Stader Splint which has marked a distinct milestone in the treatment of fractures was first developed by a veterinary surgeon and later applied to the care of *homo sapiens*. This gave one of our veterinary friends an opportunity for a little fun at the expense of the medical men.

Being possessed of as fine a professional appearance and manner as could be desired, even to the portly waistline and slight wheeze, he wasn't even asked for his badge by the doorkeepers at the Canadian Medical Convention in Toronto this summer —in fact his obvious credentials sufficed to admit one of his pals also. Joining a group of medicos discussing a skeleton wearing a whole crop of Stader splints, they cleared their throats and took over the discussion.

"We surgeons certainly must hand it to the vets—that's a great invention!"

"These veterinarians must get a scientific training quite as good as ours!"

"You're right — our fellows wouldn't have thought that out in a hundred years!"

("And the best part of it," says our veterinary friend, "is that we had most of the doctors agreeing with us by the time we moved on!")

Buy Victory Bonds; Shorten The War!

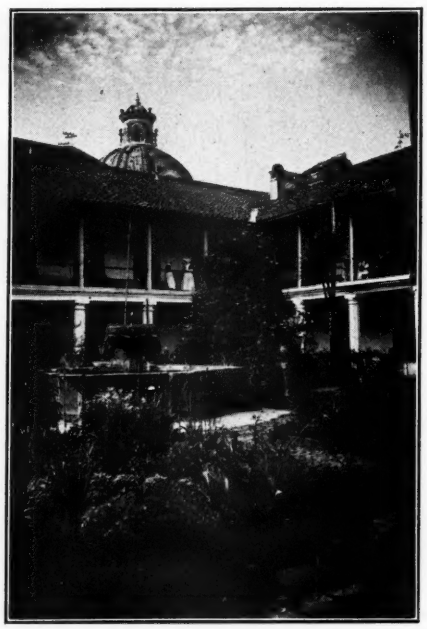
Another "Oldest" Hospital

A portion of the eastern wall. The arch in the background is really a bridge, somewhat reminiscent of the Venetian Bridge of Sighs.

VARIOUS statements have been made as to the oldest still-operating hospital in America. It is generally agreed that the Hotel Dieu de Quebec (1639) is the oldest in either the United States or Canada. References have been made also to the old hospital in Mexico City, the Hospital de Jesus, built by Cortez in 1524.

Another contender for this bewhiskered honour is a hospital in Quito, Ecuador, founded March 9th, 1565. Now known as the *San Juan de Dios,* it is believed to have been called originally Misericordia de Nuestro Senor Jesucristo.

We are indebted for the illustrations reproduced here to the editors of the *Bulletin of the Hospital Association of Pennslyvania,* who, in turn, obtained them from Mr. Eichenlaub and Dr. Landon of the Western Pennsylvania Hospital.



Left: This "new section" was started in 1850 over part of the old site. It is used by the women's service and surgery.

Below: The two recesses marked "tarima" were made up as beds. They have not been changed since construction in 1565, though no longer used. The building above the recesses was re-constructed in 1750 and is still in use.

"While the ancient recesses, called tarimas, appear most primitive to our modern eyes, it would be a mistake to infer that the care given in those days was equally primitive. The humanitarian and sympathetic care given those old patients, indigent as well as well-to-do, was in sharp contrast to the inhuman practices which prevailed in most European institutions of the period.

This solicitude for the sick and indigent was a sentiment universally held in the old colonies, as evidenced by the vast sums the charitable-minded turned into their hospitals."

Hospital Policy for Toronto Outlined by Special Committee

The Advisory Committee on Hospitalization and Public Welfare of the City of Toronto has reported to the Board of Control respecting various requests for assistance in the building of hospitals.

After reviewing the shortage of hospital beds in the city, a number of recommendations are outlined.

It would be in the interests of a high standard of hospitalization if some amicable and neighbourly arrangement could be made between the city and neighbouring municipalities to co-operate in the financing of hospitals. Failing such arrangement, some measure of government direction should be obtained.

The city should, by way of civic grants, provide financial inducement to the hospitals contemplating new buildings or additions to existing premises to proceed with such work as expeditiously as possible. Increased hospitalization for incurables should receive first consideration.

Early attention should be directed to the further provision of new incurable hospital accommodation which, if suitable and centrally located, might be designed to accept and segregate patients who may, for a time at least, only require minor care, as well as those more seriously ill, thus more promptly relieving the pressure upon the principal general hospitals.

Accepting the desirability that teaching hospitals be centrally located and convenient to the medical school, it is recommended that new general hospital facilities being proposed be located in areas not now provided with sufficient hospital accommodation.

With a view to spreading the burden of providing the funds required for construction, it appears to your Committee that as a general policy an equitable distribution of such costs would be as follows:

1/3 by the hospital board;

1/3 by the Provincial Government;

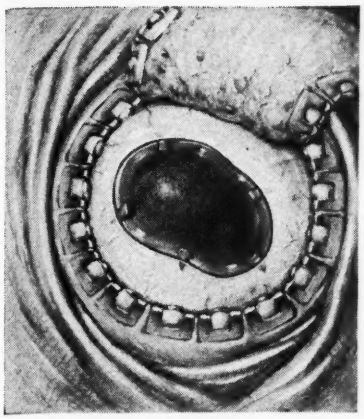
1/3 by the City and other municipalities whose citizens availed themselves of this accommodation in the ratio that the total number of city patients and those from other municipalities bear to the total number of patients cared for in the institution for the previous year.

The Committee accepts the opinion that 65 beds per 1,000 of population should be available in the city. It would appear that these figures would apply to general hospital beds only. Actually the city has slightly over that ratio (4,400 general hospital beds for 674,000 persons), but as 23 per cent of the patients receiving care in 1943 were non-resident, that is from neighbouring municipalities and elsewhere, only 48 beds per 1,000 are available in general hospitals. This would indicate a deficiency of 1,100 beds in general hospitals. The Minister of Health for the Province is quoted as stating that the city should have 1,440 additional hospital beds, of which one-half (or 720) should be for chronically-ill patients, 360 in general hospitals and the remaining 360 in convalescent accommodation. (See Obiter Dicta.)

Versatility on the West Coast

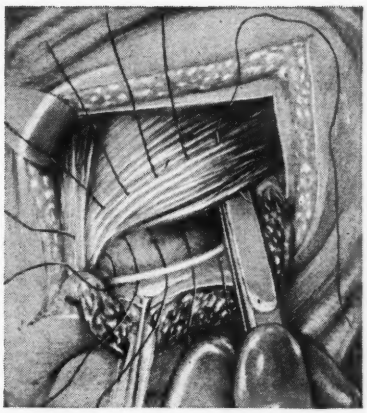
In these days of personnel shortage an administrator must be able to turn his hand to anything. Here Dr. T. W. Walker, superintendent of the Royal Jubilee Hospital, Victoria, and President of the British Columbia Hospitals Association, takes over the controls of the big power shovel excavating last month for the new 75 bed maternity pavilion of the Hospital. And see what he scooped up on his first try! None other than Miss Rowena Ashby, secretary in the engineering department. Trust Tommy, the Vancouver Island fashion plate, to make a good catch!

(Photograph by "The Daily Colonist" Victoria)



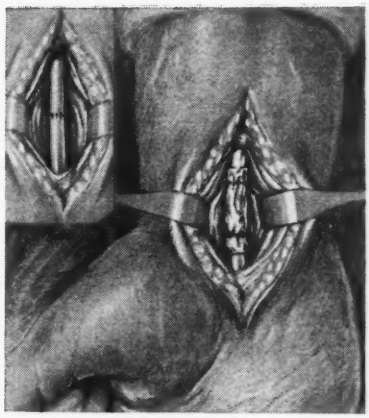
SKULL REPAIR

Tantalum plate inlaid on bone shelf surrounding the defect. Plate is flush with skull surface and secured by triangular tantalum points.



HERNIOPLASTY

Modified Bassini operation. Tantalum sutures approximating external oblique aponeurosis to Poupart's ligament. Of value in recurrent hernia or in infected areas.



NERVE REPAIR

(*Inset*) Fine gauge tantalum sutures approximate epineurium of severed median nerve . . . Tantalum foil wrapped loosely about repaired section and secured by loose ties.

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LIMITED SUPPLY NOW AVAILABLE FOR CIVILIAN USE

● Tantalum, widely used in war surgery, is now available in limited supply for civilian use. Present experimental and clinical evidence indicates that tantalum is superior to silver, steel and alloys as a metallic substance for non-absorbable sutures and bone plates. Investigators report it to be inert, non-corrosive and non-electroactive. It produces minimal tissue reaction. It has high tensile strength, exceptional malleability, and is impermeable. Tantalum may be boiled or autoclaved.

ETHICON TANTALUM SUTURES are 2½ times as strong as U.S.P. requirements for catgut (knot pull). Sizes 6-0, 5-0, 4-0, 18" long, swaged to ⅜ Circle Taper point Eyeless Atraloc Needles. Used and tied in same manner as other non-absorbable sutures.

ETHICON TANTALUM WIRE. Suturing material on spools, without needles. Sizes 6-0, 5-0, 4-0, 000, 0, 2, 4.

ETHICON TANTALUM RIBBON. Used for making hemostasis clips, particularly as employed in brain surgery. Tantalum Ribbon is also used in orthopedic and faciomaxillary surgery.

ETHICON TANTALUM FOIL is used as a sleeve or cuff to protect nerves and prevent adhesions of contiguous tissue.

ETHICON TANTALUM SHEET is used extensively for cranioplasty and reconstructive or plastic repair work. Easily molded to body contours.

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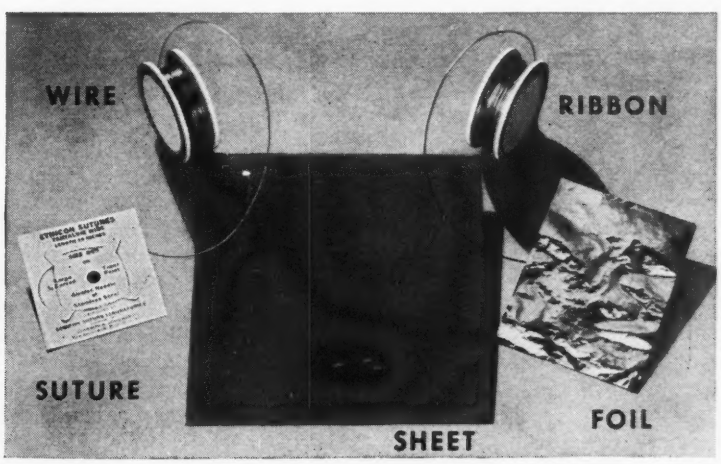

New N.S.S. Regulations to Help Hospitals Obtain Nurses

IN AN EFFORT to assist hospitals to obtain more nurses, National Selective Service has issued a new Directive (No. 356) designed to overcome some of the handicaps affecting the return of some of the nurses to hospital employment.

Mrs. Rex Eaton, Associate Director of National Selective Service, has kindly sent us the following official interpretation of N.S.S. Directive (No. 356):

"Hospitals may continue to advertise, interview and engage nurses without reference to National Selective Service.

"In the event that any hospital might persuade a graduate nurse (not now employed in a hospital) to accept a staff position as a nurse provided that financial assistance were made possible, National Selective Service has authorized the following supplementary allowances;

1. Transportation to place of employment. Travelling allowance provides coach fare and meals at the rate of .75c for breakfast; $1.00 for luncheon; $1.25 for dinner. If reservations are required, upper berth (tourist) is provided west of Montreal. (The cost of such other type of accommodation as may be considered advisable might be assumed by the hospital.) Return transportation will be paid on the same basis, provided that the nurse remains in the employ of the hospital for an agreed upon, reasonable length of time (usually six months) or until the termination of the emergency.

2. During the time lost while travelling, National Selective Service will pay .40c an hour to the nurse. In addition, National Selective Service will pay:

(a) Not more than $5.00 per week to any nurse who accepts a position as a nurse, provided that her former employment was more remunerative.

(b) Not more than $7.50 per week as a separation allowance, if the nurse will be required to live separately from persons dependent upon her for support.

(c) If necessary, National Selective Service will make a temporary advance for living expenses.

(d) A temporary advance of not more than $15.00 will be made for uniforms.

(e) Both (c) and (d) are recoverable, requiring a promissory note payable within 48 hours from the time the nurse receives the first salary, unless extended by National Selective Service.

3. Graduate nurses leaving positions outside of nursing will be entitled to reinstatement in their present employment, and those concerned will be so advised.

4. Graduate nurses who are presently unemployed or not gainfully employed (i.e. a married woman looking after her home) are entitled to all supplementary allowances. No right of reinstatement is involved, or wage differential or payment for time lost while travelling.

5. Any hospital which may find the above arrangements of assistance in securing graduate nurses for staff, should confer with the manager of the nearest Emploment and Selective Service Office in writing, if an interview by reason of distance is impossible. In letter or interview the hospital should refer to N.S.S. circular (No. 356).

6. The supplementary allowances and reinstatement privileges are authorized either by or through the local Employment and Selective Service Office.

7. The procedure connected with above requires a certain amount of time (approximately two weeks) and this should be borne in mind when discussing employment with a prospective graduate nurse employee."

Income Tax Deductions for Parents of Student Nurses

AT the last session of the House of Commons, which adjourned last month, a clause in the Bill on national finance sponsored by the Minister of Finance, provided that a parent may secure a deduction of 20 per cent of the amount contributed, not exceeding $400.00, to the support of a daughter or sister under twenty-one years of age training as a nurse at a public or provincially licensed private hospital.

This provision will meet with strong approval on the part of many parents who have complained about the lack of recognition of this type of student training and will be appreciated by directors of schools for nurses who have encountered this objection from parents of prospective students. This point has been discussed several times with departmental officials. One would have desired a larger exemption than that provided, but it has been pointed out that nurses-in-training do differ from other students in that the major items of maintenance expense are provided.

Writing on this subject to the Canadian Hospital Council, Mr. C. F. Elliott, Deputy Minister of National Revenue (Taxation), stated recently:

"I should like to add that we are or should be very conscious of the splendid work done by nurses and of the necessarily intense training which present conditions require be given to student nurses.

"Perhaps nurses above all others fill a place that should receive sympathetic consideration, and parents should be encouraged to send their children to this kind of work which is so vitally required and is of such great human value.

"Not only the medical profession but others are conscious of their splendid service, their high educational and other ever-increasing requirements as science and the nursing profession progress."

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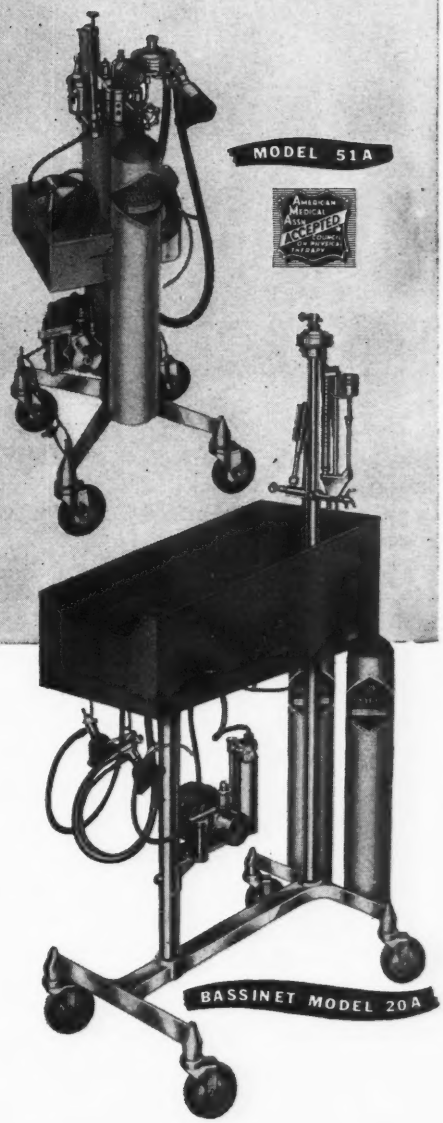
All Kreiselman Resuscitators, if equipped with the proper sizes of inhalers, are suitable for use on all patients, regardless of age. The extra convenience features of Bassinet Models present particular advantages for use on infants.

Write for literature and our recommendation for meeting *your* specific requirements.

Army-Navy E and Maritime M Flags have been awarded to The Heidbrink Division of The Ohio Chemical & Mfg. Co. for production achievement.



1 The positive pressure is readily adjustable by the operator. Pressures range from 5 to 16 mm. Hg. on all Infant Models and from 5 to 25 mm. Hg. on all Adult Models.

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3 Simple, trouble-free operation. A single instant adjustment "sets" the apparatus to deliver any predetermined pressure. Simple thumb pressure on a lever at the inhaler admits the oxygen to the respiratory system.

4 Oxygen Inhalation. Oxygen for breathing purposes in concentrations up to 100% instantly available.

5 Aspirator is electrically operated and built into apparatus. Hand bulb-operated aspirator may be substituted.

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Ontario Plan Passes 300,000 Mark.

In marking the attainment by the Ontario Plan for Hospital Care of its 300,000th participant, the above picture has been sent to us by the director, Mr. Norman Saunders.

It shows the Roswell family of Scotland, Ontario, who have recently been enrolled in the Plan. Mr. Roswell is employed at the Brantford Coach and Body Co. Ltd. of Brantford. Mr. and Mrs. Roswell have 11 children under 16 years of age, ranging from Howard, 15, to Yvonne, born this year.

At the time of going to press the membership in the Ontario Plan had mounted to 323,000.

Blue Cross Enrolment Sets New Record

The total of active participants in Blue Cross Plans on July 1st was 14,760,000, exclusive of 750,000 in the armed forces whose contracts have been deferred for the duration of the war.

Some 1,754,000 persons were enrolled during the first six months of 1944. During the second quarter the enrolment was 961,000.

New York City topped the list on July 1st with 1,606,000 and Detroit had 1,142,000. These were followed by Boston, Cleveland, Pittsburgh, Chicago, Philadelphia, Newark and St. Paul, all ranging from half a million to one million.

Fourteen medical service plans administered in co-ordination with Blue Cross Plans had a total participation on July 1st of 1,102,000.

Ontario Health Board Announced by Minister

Dr. R. P. Vivian, Minister of Health for Ontario, has announced the personnel of the Municipal Health Services Board, authorized under the recently passed Municipal Health Services Act. Members of the Board represent both those receiving services and those providing them.

Appointed to the Board are: Mrs. R. J. Marshall, Miss Jean Masten, Dr. H. D. Logan, Dr. D. W. Gullett, Mr. J. H. Bower, Mr. R. E. W. Lawrason, Mr. E. E. Woollon, Dr. K. G. Gray.

The Board was chosen from a panel of names submitted by women's organizations, the nurses, medical profession, the dental profession, the hospitals, labour and municipalities, and includes a representative of the Department of Health. The representative for agriculture will be announced later.

This Board is a corporate body and will appoint one of its own members to be chairman. It will draw up regulations which will deal with the establishment of a medical service within a community. No community or municipality can set up its own municipal physician or other health service without receiving the sanction of the Board. The Board will supervise the administration of any municipal physician or nurse set-up and will act as the agency for receiving money from the local community, and for paying for service rendered.

The Ontario Government has preferred to approach the problem of health insurance through the municipality rather than by instituting province-wide coverage in the initial step. However, by having the cost come from taxation the plan being followed would appear to be that of state medicine rather than obligatory health insurance.

Montreal Hospitals Authorized to Hire Employees Directly

THE 28 hospitals constituting the Montreal Hospital Council have been granted permission by National Selective Service to hire personnel directly for the next six months.

The personnel shortage has been so severe that a conference was held in July between Selective Service officials and representatives of the hospitals and of the provincial nurses' association. At this conference it was agreed that if substaffs could be built up the overworked nurses would be greatly assisted in their work, and would be able to devote more time to actual nursing.

Following the conference a Sub-Committee on National Selective Service under the chairmanship of Mr. Arthur W. Smith, asistant superintendent of the Royal Victoria Hospital, made the following request on behalf of the member hospitals:

"That they be granted a six-month trial period, commencing immediately, to secure all their male and female employees as in pre-war days. All members of the Council hereby agree to continue sending lists of newly-hired female employees to National Selective Service."

"In order to assist the Draft Board with those eligible for Army call-up, the members of the Hospital Council will agree to supply a confidential memorandum giving the following information for all male employees hired, (should our request be granted).

Full name of employee as stated on application forms.

Address given.

Marital status.

Last place of employment, if any."

The Administration Board of National Selective Service agreed on August 3rd that the Montreal Hospital Council "be granted a six-month trial period, commencing immediately, to secure all their male and female employees without reference to National Selective Service, except that information required for the sake of records and mobilization should be forwarded to National Selective Service".

In the case of female employees it was stated by Mrs. Rex Eaton that lists of newly-hired persons would be sufficient, and in the interval procedures have been worked out applicable to the male employees.

Mr. Smith, in his letter to Mrs. Eaton, stated:

"The Montreal Hospital Council wishes also to go on record that it appreciates the time and efforts of the National Selective Service organization and its personnel in trying to solve our problems. The Council feels that, with the many employment advantages hospitals have to offer and with the ability to engage and dismiss their employees on the pre-war basis, some immediate improvement could be made.

"The Council sincerely trusts that the National Selective Service will still be behind the hospitals of this district in their efforts to furnish the finest of service under the most trying conditions they have had to face in their history."

In her reply Mrs. Eaton stated:

"It was a pleasure for us to have had the conference with your Council and the Registered Nurses' Association in Montreal. It is, I believe, only through such co-operative efforts that at this stage of our labour situation we can hope to meet our most urgent problems. You may be assured that N.S.S., through its local offices, will continue to do everything possible to meet hospital requirements. I believe there is no other situation which is brought more forcibly to the attention of our local officers by the national organization."

(On August 25th, Mr. A. W. Smith stated that the arrangement was working out very satisfactorily. At the first of the month the Montreal hospitals were in need of 900 women and 300 male employees. On the above date there was a drop of nearly 600 in the number of women required and a slight decrease in the number of men.)

Similar Arrangement Made by N.S.S. for Hospitals in Toronto

Effective August 22nd, the Ontario Regional Superintendent of the Unemployment Insurance Commission announced to the Toronto Hospital Council that new arrangements were being made for the recruiting of workers for hospitals in that city.

Each hospital will continue to file orders for help needed with their local Employment and Selective Service Office, which office will continue its efforts to refer applicants to such orders.

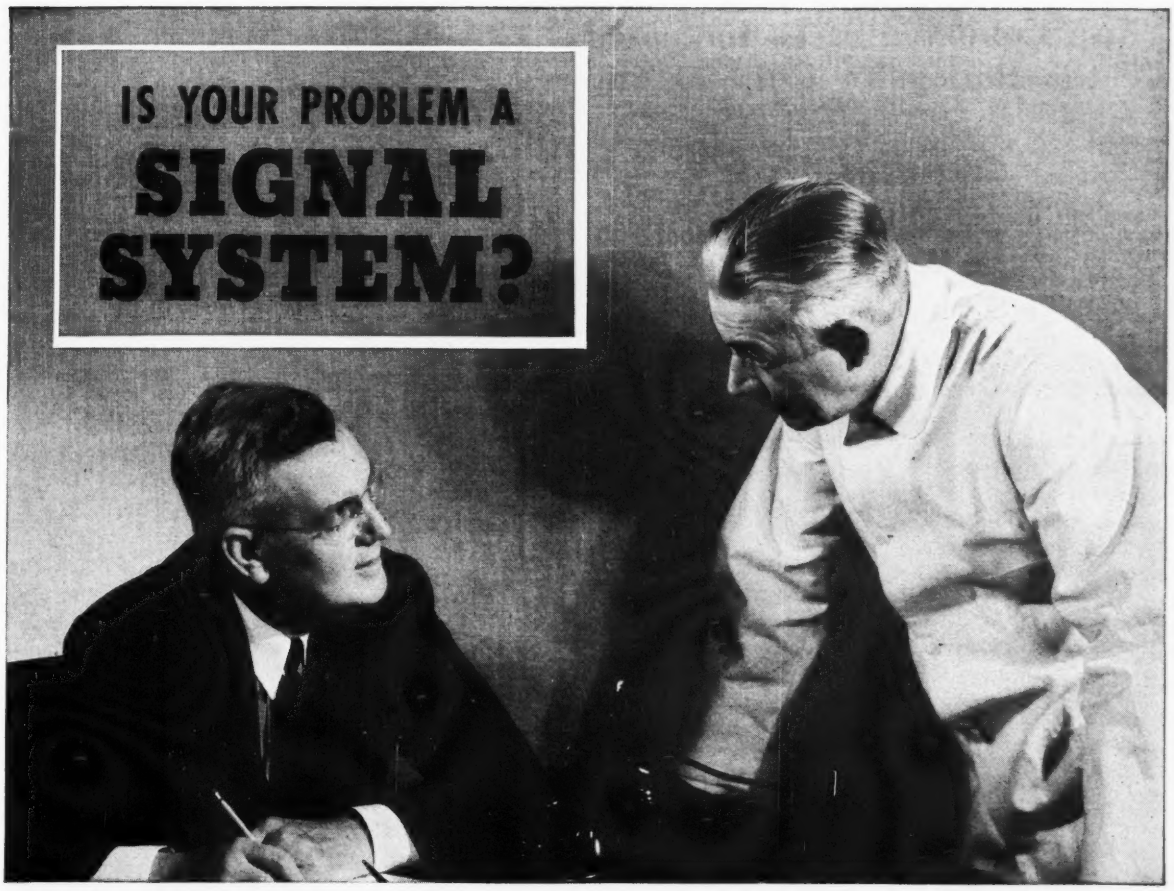
Each hospital or the Toronto Hospital Council may advertise for help in its own name. Applicants are to apply directly without previous reference to National Selective Service. However, a copy of the advertisement should be forwarded to N.S.S. for record purposes.

Each hospital may interview or hire applicants, male or female, without prior reference to National Selective Service. The engaging hospital, however, shall send full details within 48 hours to the nearest Employment and Selective Service Office. That office then, if the engagement is in order, should issue the necessary N.S.S. permit.

All applicants must be questioned regarding their present employment; if engaged in essential industry, they must be referred to National Selective Service for clearance, before engagement.

If the applicant has a notice of separation (N.S.S. 120 or 208), he may be engaged to commence work on any date subsequent to that time shown as the effective date of the notice of separation. The engaging hospital will pick up the notice of separation and within 48 hours forward it to the nearest Employment and Selective Service Office with the information requested above, respecting name, address, age, position, wages, etc.

This arrangement will remain in effect until February 28th, 1945, but is subject to cancellation without notice.



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British Columbia Seeks Increased Gas Ration for Hospital Nurses

THE British Columbia Hospitals Association has requested an increased supply of gasoline to permit nurses doing part-time work at nearby hospitals to use cars for their transportation to and from their hospital. The shortage of nurses is a very serious problem for the hospitals in British Columbia, as it is in other parts of Canada. On the Lower Mainland and on Vancouver Island the tremendous increase in population has taxed hospital facilities to the limit. An effort is now being made to induce married or retired nurses to do part-time work in nearby hospitals, but in many cases this is only possible if adequate gasoline be supplied for their transportation.

* * *

August 4th, 1944.

Office of the Oil Controller,
815 Hastings Street West,
Vancouver, B.C.

Dear Sir:

As you are no doubt aware, the shortage of nurses is becoming a very serious problem for the hospitals. Many nurses have joined the services, others have married and some have gone into war industries. Hospitals are being hard put to it to maintain their essential staffs. On the other hand, owing to the increase of population due to war conditions, particularly on the Lower Mainland and on Vancouver Island, hospital bed capacity is being taxed to the limit. In this district—and what applies to this district no doubt applies to many others — there are several women who were nurses before they married and who would be quite ready to do part-time work in the local hospital if they could drive to and from their homes. But their gas ration is not sufficient to allow them to do this.

Recently I wrote to the Transport Controller to ask him whether he had any objection to the B.C. Hospitals Association holding a convention this coming October. He replied that so far as he was concerned, the convention would come under the heading of conventions in aid of the Canadian war effort. We are told over the radio that there are more cars on the road today than there were this time last year, and the occupants of a very large number of them are certainly purely on pleasure bent. Would it not be possible for the women to whom I have referred to obtain an extra ration in order to help out the hospitals in the very difficult situation through which they are passing? I am confident that the hospitals would see to it that the privilege was not abused.

(Signed) E. W. Neel,
Secretary, B.C.H.A.

Reply

Office of the Oil Controller.
Vancouver, B.C.
August 8th, 1944.

Dear Sir:

We have your letter of August 4th and can quite understand the difficulty being experienced by many hospitals in various parts of the province on account of the shortage of nurses.

Unfortunately the gasoline supply situation, particularly in this area, is extremely critical and special category can be granted only to cars that must necessarily be used extensively for essential business purposes, which does not include personal transportation between place of residence and place of work.

Registered nurses on call requiring to use their automobiles can be given special category but nurses employed in hospitals and using their cars for their own transportation from where they live to the hospital where they are employed must use their "AA" category coupons.

(Signed) A. Curry,
Regional Director, Gasoline Rationing for the Oil Controller for Canada.

* * *

This request of the British Columbia Hospitals would seem very timely. For a long time workers in war industries living more than a stipulated number of miles from their work have been given the necessary gasoline for their transportation to and from work. In some instances this has amounted to considerable mileage. Hospital work has been rated as highly essential and it would seem to us that the maintenance of hospital staffs is a great deal more essential to the national welfare than are many of the commercial and other categories for which extra gasoline is allowed.

Hospitals in Ontario Required to Place Employees Under W.C.B.

Hospitals are now finding that at the last session of the Ontario legislature an amendment was made to the Workmen's Compensation Act, requiring employees of hospitals and sanatoria in Ontario to be covered by workmen's compensation. On and after January 1st, 1945, the operation of hospital and sanatoria is subject to assessment by the Board, and employees injured by accident are entitled to compensation under the provisions of the Act. Payroll forms are being made available to hospitals on which they will make an estimate of the amount expected to be spent on wages for all employees during the year 1945. This form must be returned to the Board by January 20th, 1945.

News of this arrangement was quite a surprise to many hospitals at the end of August as they had not been notified either of the proposed legislation or of its enactment. Apparently the legislation committee of the Ontario Hospital Association were not aware that this was being brought up. One member of the Board of Directors of the Association expressed much concern that a matter of such serious consideration to hospitals now caring for their employees on a much broader basis than the new coverage provides, should be brought up and passed at the end of the session without the knowledge of the hospitals concerned.

Book Review

HOSPITAL COLOUR AND DECORATION—By Raymond P. Sloan, Editor, *The Modern Hospital*. Pp. 240, 24 full-page illustrations, floor arrangements, colour charts, etc. Price $3.75 (U.S.A.). Physicians' Record Company, Chicago. 1944.

Raymond Sloan's excellent work on *Hospital Colour and Decoration* is the latest of the highly-practical books on hospital topics published by the Physicians' Record Company, and is a worthy addition to that select list. More and more it is being recognized that good taste in decoration and the proper use of colour are factors which are of the utmost importance in winning the confidence and the enthusiasm of the patient, the public and the staff. Not only are pleasant surroundings more restful but, in the case of patients, can have definite therapeutic value.

The author, himself a hospital trustee and favoured with unusual opportunities for observing the best anywhere in hospital development, has brought together in this volume an unusually fine collection of ideas and suggestions for removing the institutional atmosphere of the hospital and substituting therefor the relaxing atmosphere of the home. He starts at the front door and, in succeeding chapters, shows how to colour and decorate the foyer, the corridors, the wards and rooms, the nursery, the solaria, the roof garden, the offices and the residences for the nurses and staff. He even prescribes for the room in which expectant fathers are to be segregated and guarantees that any hospital following these ideas can make fatherhood practically painless. No wonder—what with hunters in pink coats jumping all over the walls, comfortable chairs in the tavern tradition, settles on either side of the fireplace, red leather cushions, a rough-hewn oak table, a suspended waggon-wheel lighting fixture, pewter mugs, backgammon sets, dice and chips, a bottled drink dispenser and an assortment of distinctly men's magazines — so he can forget his troubles, not improve his mind. Who wouldn't brave the trials of paternity!

Much helpful advice is given on the choice of furniture, on rugs, curtains and other accessories. He believes in decorating men's wards as fit abodes for he-men, and vice versa. There is much useful information on landscaping and on the plants and other decorative features of the roof garden. Ray Sloan writes in a light, breezy style which is as refreshing as the subject matter itself. One could wish some of the excellent illustrations could have been in colour to illustrate his recommendations; however, an extensive colour chart is appended which in itself would be helpful in working out appropriate tints and tones. Every hospital house committee and women's auxiliary should be familiar with this book.

Work Begins on Annex to Hospital

Work has begun on the enlarging of the St. Sacrement Hospital, Quebec City, at an estimated cost of $550,000. Three new wings will be built on to the original building. The three new wings are to have four floors as well as basement and will be completely fire-proof. These wings will house the nurses school and the quarters of the hospital personnel and will permit the hospital to increase its number of beds from 200 to 300.

New Superintendent for the Sarnia General Hospital

Miss R. M. Beamish has taken over her duties as superintendent of the Sarnia General Hospital. Miss Beamish was former superintendent of the Memorial Hospital at St. Thomas, the General and Marine Hospital in Owen Sound, and assistant superintendent at the Toronto Western Hospital. Miss Beamish is to have complete supervision of all the branches of the Sarnia General Hospital under what constitutes a complete reorganization.

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Control Board Rulings

Electric Fans

The purchase of electric fans was restricted, by W.P.T.B. Order A-1036, effective July 28, to those to be used in hospitals, industrial establishments, on naval and cargo vessels or for use of the armed forces. Fans bought after July 28 must not be used for any other purpose. Every manufacturer, wholesaler or dealer who sells electric fans must deliver to the administrator of capital equipment and electrical products by August 24, and on or before the 24th of every month thereafter, a list of all sales for the preceding month, giving the names and addresses of purchasers, use for which the fans were purchased, dates of sales, quantities, catalogue numbers and sizes. Only in case of undue hardship, and with written permission, may exceptions be made.

The manufacture of electric fans is still restricted to those made for the above essential uses, and such fans may be manufactured with the written permission of the administrator.

No restrictions are placed on the manufacture, sale or delivery of spare parts and replacements.

Nurses' Shoes

To ensure a reasonable supply of nurses' white oxfords for nurses who are actively engaged in nursing, arrangements have been made by which nurses' white shoes manufactured after June 1st shall be stamped "Made under permit for nurses only". From the same date manufacturers must obtain an agreement from their customers that these permitted shoes will be sold only to nurses.

Each retailer who receives delivery of any shoes made with this permit stamp must obtain a signature from the nurses buying these shoes. These signatures must cover the sale of every pair of these shoes bought and must be kept on a card or in a book for that purpose, to be available for inspection by the supplier or by the Board officials any time. The nurses' name, address and hospital or other connections should be stated in these records.

Price Trends

(On basis 1926 = 100)

	Yearly Average 1943	July 1943	June 1944	July 1944
Building and Construction Material	121.2	119.6	127.4	127.2
Consumers' Goods (Wholesale)	97.0	97.4	97.4	97.4
	(On basis 1935-1939=100)			
Cost of Living	118.4	118.8	119.0	119.0

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An authoritative statement

'The most reliable procedure for the complete 'elimination of streptococci from the naked 'hands is as follows. Wash for one to two 'minutes in a pint of warm water, using plenty 'of yellow bar soap and a nail brush to the nail 'sulci ; then pour into the palm of one hand a 'teaspoonful of neat Dettol . . . . . and 'work into the skin of the hands till dry (one 'to two minutes).' ❖

An antiseptic with a high Hygienic Laboratory coefficient whose bactericidal activity is well maintained in the presence of blood, pus and other organic matter; which is lethal to a great diversity of bacteria, including haemolytic streptococci : which is non-poisonous even at full strength and applicable, without causing pain or injury, to raw wounds and surfaces : which does not inhibit the natural processes of repair : which is stable at all clinically desirable temperatures and at all dilutions : which is non-staining, agreeable in use and pleasant to smell.

This list of qualities might well describe the theoretically ideal antiseptic. In fact it describes 'Dettol'—which in ten years has become the antiseptic of choice, for the protection of patients and staff alike, in nearly every hospital in the British Empire.

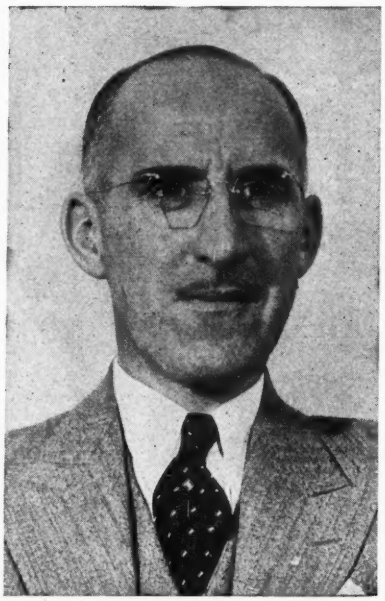
❖ Colebrook, L. (1933) *British Med. J.*, **2**, 725.

C. C. Gibson Accepts Provincial Post

Mr. Clarence C. Gibson, who has been superintendent of the Regina General Hospital for a number of years, has resigned his position to become a member of the Saskatchewan Health Service Commission and to be in charge of Hospital Administration for the Province.

Mr. Gibson assumed his new duties on September 1st. It is understood that he will make a thorough inspection and survey of the hospital facilities throughout the province this autumn. As the new government has definite views about hospitalization, it is quite probable that Mr. Gibson will find his position a very active one.

The Regina General Hospital has made much progress during the years of Mr. Gibson's administration. New accommodation and new services have done much to improve the value of the hospital to the people of that city and province. Mr. Gibson has enjoyed to a high degre the confidence of his Board, the staff and the citizens of Regina. Prior to his departure, the Board of Governors tendered a farewell dinner at the Assiniboia Club to Mr. and Mrs. Gibson and made them a very handsome presentation. The Nursing and Lay Staffs of the hospital also expressed their regrets with very acceptable gifts.



Hospital Proposed as David Hornell Memorial

A lakeshore community hospital, to be called the David Hornell Memorial Hospital, has been suggested as a memorial to Flt. Lt. David Hornell, V.C. The hospital would be a joint undertaking, with Mimico, New Toronto and Long Branch contributing.

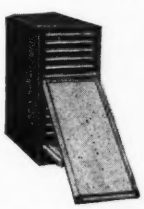
Public Health Training Grants

Canadian medical officers who desire to take special training in public health work on demobilization will receive special grants made up by the Province of Ontario, the Federal Government and the Rockefeller Foundation. Married men will be paid $200 a month, single men $145.

Heads Field Ambulance

Lieut.-Col. Joseph Tanzman, R.C.A.M.C., Officer Commanding the 14th Field Ambulance in France, was recently promoted to that rank. Prior to enlistment he was on the staff of the Saint John General Hospital, and is a past president of the Saint John Medical Society.

He's Got a Right to be Sore . . .



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A.H.A. Convention in Cleveland Promises a Fruitful Week

The advance programme of the American Hospital Association Convention to be held in Cleveland on October 2nd to 6th indicates that this will be an unusually fine meeting. A well-balanced programme has been arranged for the various sections, with programmes of interest to trustees, nurses, administrators, record librarians, social service workers, medical staffs, dietitians and others.

Special sessions will be devoted to postwar planning, small hospitals, public health, children's hospitals, rural hospitals, purchasing, Blue Cross plans, business management, construction and mechanical operation, personnel and public relations. There will be one session devoted to the problems of the volunteer.

At the President's Session on Monday night the president-elect, Dr. Donald C. Smeltzer of Philadelphia and formerly of the Montreal General Hospital, will give the annual address. Tuesday night is devoted especially to trustee problems, Wednesday night is to be a "United Nations" session, with a very colourful and interesting programme, and Thursday night has been set aside for the Annual Dinner and Dance.

The House of Delegates, on which Canadian representatives from every province sit, will meet on Sunday, October 1st and at selected intervals during the week. The convention will close, as in previous years, with a general round table and open forum held by Dr. Malcolm T. MacEachern and Mr. Robert Jolly.

The American College of Hospital Administrators will hold its Annual Convention on Sunday, October 1st.

Ontario Co-Operative Sets up Hospital Plan for Members

A Credit Unions Mutual Benefit Association, known as "CUMBA" was set up by the Toronto Credit Union in June. This is designed to provide hospital and sickness benefits and later medical benefits to members. Credit unions will pay yearly in advance for its members joining CUMBA, thus reducing collection costs.

Hospitalization benefits are of the conventional type. Up to 31 days hospitalization will be provided for treatment, but not for diagnosis. Where a married couple have been enrolled for one year, 50 per cent of maternity hospital costs may be paid. After two years membership, full costs are paid.

Sick benefits provide for payment of $10 weekly up to 13 weeks in any one year.

Two classes of hospital accommodation are provided. Semi-private accommodation up to $4.50 a day for the member, his wife and children under 16 costs $1.50 per month. Standard ward care for the family up to $3.00 costs $1.00 per month. Single person rates are 75c per month for the semi-private plan and 50c for the standard ward plan. Participation in the sick benefit service would cost the member 65c monthly. It will be noted that the benefits and the costs to the subscriber closely parallel those of the Ontario Plan for Hospital Care. (See Obiter Dicta.)

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Minimum Hospital Food Allowances

A table of minimum allowances of essential foods needed for hospital patients.
Prepared by the office of Food Distribution, War Food Administration at Washington.

Food Groups	Weekly amounts per capita*	Members of Food Groups
A—Milk or milk equivalent	7 qts. of which 3½ qts. is whole fluid milk	Whole milk, evaporated milk, dried milk, skim milk, skim dry milk, ice cream, cheese
B—Fats	1 lb. ½ lb. ½ lb.	Butter, margarine Lard, oils, shortening
C—Eggs	10	None
D—Meat, poulty, fish	3 lbs., **of which 1½ lbs. are to be from items starred**	Beef*, veal*, lamb*, mutton*, pork*, chicken, turkey, duck, fish, all kinds including shellfish, rabbit, guinea, game, wild fowl (eggs and cheese from other groups may substitute in part)
E—Citrus fruits and tomatoes	3 lbs.	Oranges, grapefruit, lemons, limes, tangerines, tomatoes
F—Leafy, green and yellow vegetables	4 lbs. of F and G—at least 2 lbs. **of F, of which ½ lb. is from items starred**	Spinach, chard, asparagus, kale, collards, mustard greens, turnip greens, okra, lettuce*, chicory*, cabbage, Brussels sprouts, broccoli, peas, green beans, water cress*, parsley*, peppers, pimiento, carrots, rutabagas, yellow squash, pumpkin, escarole*, endive*
G—Other vegetables and fruits	The remainder of 4 lbs. from G	Turnips, beets, celery, cauliflower, parsnips, salsify, radishes, onions, bean sprouts, kohlrabi, rhubarb, cucumbers, eggplant, squash, sweet corn, apples, apricots, peaches, bananas, pineapple, pears, grapes, plums, avocados, figs, raisins, prunes, dates, persimmons, pomegranates, nectarines, papayas, watermelons, berries, cantaloupes, cherries, currants.
H—Potatoes (white and sweet)	2 lbs.	(Macaroni, spaghetti, noodles, rice, hominy, grits from cereals may substitute during an acute shortage)
I—Cereals and Breads	3½ lbs.	Breakfast cereals, flours, meals, grits, breads of products of wheat, corn, oats, rice, barley, rye
J—Sugar	1 lb.	(Honey, maple syrup, molasses, may substitute in part only for cane or beet sugar.)

* This column refers to allowances, per PATIENT per week. Allowances per EMPLOYEE per week, as stated in the directive, are the same as for the general population, and are in addition to a hospital's allowance for its patients.

This table was prepared to determine whether or not hospital patients are suffering from a shortage of any of the essential food groups. The ability to procure the weekly amounts per capita from any combination of commodities in an essential group should enable a hospital to maintain satisfactory nutritional diets. The purpose of this list is to minimize unjustified demands for greater food allowances. The directive indicates that hospitals should not expect supplies of food for their staffs greater than those available for other civilian groups within the community.

Charges for Penicillin

A number of hospitals have made inquiries concerning the charges that should be made for penicillin. Because of the likelihood that a large proportion of the supplies of penicillin will be utilized in caring for indigent patients or others who cannot meet the additional cost, it has been felt that it would be necessary to set sufficient rates for private patients to permit the utilization of a reasonable amount of penicillin for non-pay patients.

Until such time as arrangements can be made, either with the province or with the municipalities, to provide free penicillin for those unable to afford it, the Toronto Hospital Council at its regular meeting on August 15th, agreed that the resale charge to paying patients would be a 50 per cent advance on basic cost. This would mean a present charge of nine cents.

Hospitals advancing the resale price more than 10 per cent are required to make sales tax returns for such sales, as in the case of other drugs.

Information received by the Canadian Hospital Council from Ottawa indicates that there is no machinery available in the Department of Munitions and Supply whereby any penicillin can be issued to hospitals free of charge by the Federal Government. The Controller of Chemicals buys and sells penicillin as a necessary step in the control of production and use of the drug.

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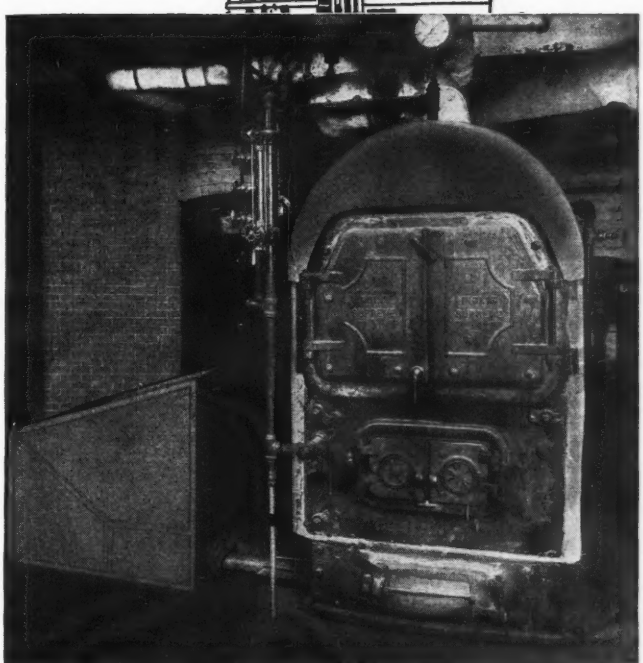

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Cheese and Typhoid Fever

A wide-spread epidemic of typhoid fever involving many cases and several deaths, with cheese as the source of infection, was recently reported from Alberta. This is by no means the first epidemic of typhoid fever traced to cheese, nor will it be the last. The cheese-making industry has not considered it profitable or necessary to institute methods in the manufacture or distribution of cheese which would ensure a safe product. Legislative authorities have not found it expedient to require such precautions. When a sufficient number of similar outbreaks due to Canadian cheese have occurred, here and abroad, both the home market and the export market will suffer materially. It will then be profitable for the cheese-making industry to ensure, and expedient for legislation to require, a safe product. In the meantime, democracy will continue to suffer from one of its own vices, that unwritten rule by which expediency rather than principle governs policy —a privilege and, to some, a virtue of democracy.

The question as to whether or not pasteurization of the milk or pasteurization at any stage in the cheese-making process destroys the flavour or injuriously affects the quality of cheese is still a controversial one, with the authoritarian voice speaking on both sides of it. Authority and old cheese go well together, and who would want to lose the nippy flavour or the crumbly texture of good old Canadian Chedder? But the time is long overdue when those authorities responsible for the welfare of the cheese industry in Canada should have provided, by adequate experiment, unequivocal and completely convincing data for or against the effects of pasteurization on cheese flavour and quality. If pasteurization does effect the flavour and quality of cheese unfavourably, ways of overcoming these effects might be found or other means of control of infection employed.

Experience has shown that typhoid fever epidemics due to cheese have been limited to cheese under three months old, the ripening process being markedly deleterious to the typhoid organism. It is fortunate that this is so. It is understood that, at the outbreak of the war, the military authorities, acting on principle rather than on expediency, prohibited the purchase of cheese under three months old for use in the Army. That practice has, it is said, maintained the Army free from any outbreaks of typhoid infection due to cheese and at the same time provided a more palatable, even delectable, product for the mess table. But the civilians can obtain, for the most part, only unripened cheese, in spite of their ruminating and grumbling at the lack of any nip that bites the tongue and makes one reach for still another piece. Is it impractical to require that cheese for civilian use should similarly be at least three months old? Where do the various departments of agriculture, in their proper concern for the welfare of the cheese-making industry, stand on this question? And where do the various departments of health stand, in their proper concern for the welfare of an unsuspecting and unprotected public?—*From Canadian Journal of Public Health.*

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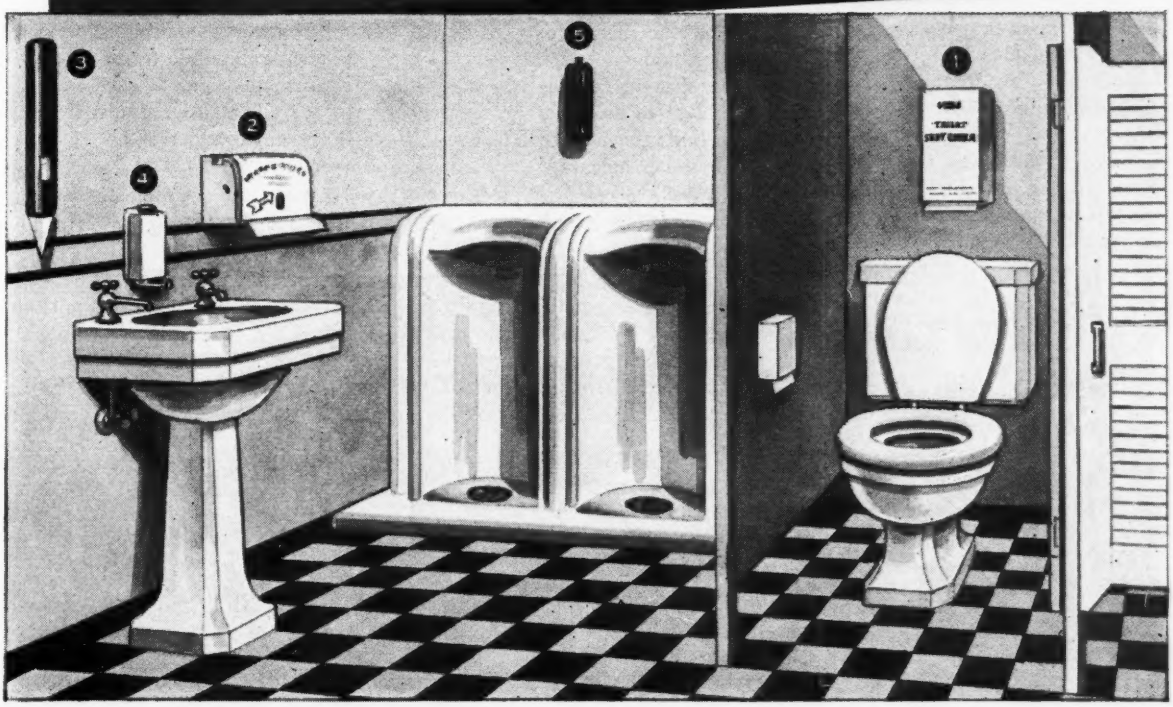

GOOD HEALTH is the most *cherished* asset of any man or woman . . . employee or customer . . . nothing is more vital, more important. Every means to prevent the spread of vermin, skin and other infectious diseases is the duty of all who are responsible for the sanitary condition of public washrooms and who are in this manner charged with the welfare of those who use such washrooms.

In the above illustration are shown many Hypro Products that help you achieve this objective.

1. Hypro Interfold Tissue Toilet Seat Covers . . . Individual sterile tissues giving complete protection, instantly self-removing and self-disposing.
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Codeine Regulations Amended

THE regulations respecting the sale and use of codeine were amended by Order-in-Council on August 8th.

An amendment of considerable importance to the practising physician is based upon a recommendation of the Canadian Medical Association, and provides that a written order or prescription, signed and dated by a physician whose signature is known or verified, shall be required except

"in the case codeine or codeine mixed with other medicinal ingredients, upon an order or prescription communicated by telephone to the druggist by a physician who states that an emergency exists in relation to a specified patient and undertakes to deliver within thirty-six hours of the time that the order or prescription is so communicated to the druggist an order or prescription therefor duly signed and dated".

A new section is added stating that where reference is made to "codeine" or "straight codeine", the regulations shall apply to codeine alkaloid, codeine phosphate, or any other form of codeine or its salts, in either powder, liquid or tablet form, unmixed with any other medicinal ingredient.

Section 3 of the Order-in-Council of June 10th, 1943, is amended by adding the following sub-sections:

"(3) It is not a defence to a prosecution for an offence against sub-section one of this section to show that the codeine was supplied pursuant to an order or prescription communicated by telephone by a physician unless:

(a) the order or prescription was actually so communicated or, if the order or prescription was communicated by a person pretending to be a physician, the druggist believed that it was communicated to him by a physician and that he had obtained confirmation thereof by telephoning the physician at his office or residence before filling the order or prescription, and

(b) the druggist made a record of all details of the order or prescription at the time it was received by telephone.

(4) No retail druggist shall, within a period of twenty-four hours, sell or supply, pursuant to orders or prescriptions communicated by telephone, more than two grains of codeine for the use of any patient.

(5) Every physician, who communicates an order or prescription for codeine to a druggist by telephone, shall within thirty-six hours confirm the same to such druggist by a written order or prescription duly signed and dated."

It should be borne in mind that Section 4 provides that any person guilty of violation of Sections 2 and 3 of the regulations shall be liable to a fine not exceeding $1,000 and not less than $200, or to imprisonment for a term not exceeding 18 months, or to both such fine and such imprisonment.

Personnel Management

(Continued from page 35)

This would enable her to see at a glance the position of her staff and how each duty is being covered, especially under the trying times through which we are now passing.

Employees' Rest Room Facilities

Every hospital administrator is responsible for providing proper rest rooms for both sexes. These must be well-lighted and comfortably furnished with couches and easy chairs. Each employer should have individual properly-constructed lockers and heated dressing rooms with sufficient ventilation. There should be provided, also, sufficient toilets, wash basins, paper towels and soap; above all, these places should be regularly inspected and kept clean. Laundry employees should also be provided with showers. Reading material could be supplied for the employees from the hospital library, or monthly subscriptions to popular magazines paid for by the women's auxiliary board. The water cooler or cold drink machines should be kept filled. Have definite rest periods of 10-15 minutes in the morning and afternoon, or if the staff be on a shift basis, on the shifts. By having your employees satisfied you are selling hospital service.

Records

By establishing a personnel department you are in the position of having all employees' records centralized. A complete story should be available from the time an employee commences duty until the date of his termination of employment, at which time his record is filed away in a special reference file.

Application Form

This is the key form. Questions should be set out in simple English and each one should be filled in where applicable. A point to watch is the previous employment record; do the dates correspond to particulars given in personal interview? Have a definite policy of checking with previous employers' references and, if still in doubt, get a confidential credit report on the applicant.

The hospital administrator may be able to arrange with the local police department or R.C.M.P. branch to have any or all names checked with their files.

A further step may be taken by training a person in your personnel department to take finger prints. The course of instruction is short and it is surprising how soon one becomes familiar with the different prints. Should finger-printing be adopted, prints may be forwarded to Ottawa for checking with centralized police files.

Every new employee should have a complete medical examination before commencing duty. Should this not be possible, do so as soon as possible after commencing duty. Where this system is carried out, the employee should be informed that, if his examination is not satisfactory, he will not be allowed to continue his employment.

There should be a periodical medical examination system and this must be strictly followed. No better method exists to prevent spread of infection and to give all patients the protection they deserve

Looking East from the King's Bastion, Citadel Hill, showing the Chateau Frontenac Hotel and Dufferin Terrace in the foreground.

QUEBEC . .

1635 An Important Hospital Date

WHEN in 1635 the Duchesse d'Aiguillon, niece of Cardinal Richelieu, sought help from her connections in the old world to establish a hospital in Quebec, she laid the foundation for the fine hospital facilities that are enjoyed throughout Canada to-day.

L'Hotel Dieu de Quebec, (oldest hospital on the continent) as well as other renowned hospitals in Quebec City, have a heritage of service that serves as an inspiration to all those engaged in the care of the sick.

The trademark of an old established organization that is equipped to give hospital buyers, physicians and surgeons the best possible service under wartime and post-war conditions.

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These outline the complete progress as to the employee's ability to work; the type of employee he really is at heart; absenteeism record with the reasons for same; promotions if any, with complete dates; title of new position and salary range; accident record with dates of each; type, cost and duration of unemployment; hospitalization record; type of illness, costs (if any), duration of convalescent period and date returned to duty; special remarks—this may cover a bonus for new safety devices, good judgement on his part for the prevention of an accident to an employee, or some patient in the hospital; termination of employment—how this came about, names of others who may have been responsible; if an accident, how it happened and dates with details; if pensioned, age and date and amount of allowance; if through sickness or death, all details should be fully explained.

Other records which should be kept are:

Payroll records and time books,
Tax deductions,
War Savings deductions,
Victory Bond deductions,
Health Insurance deductions,
Group hospitalization deductions,
Pension fund deductions,
Pay voucher forms,
Transfer forms,
Job analysis forms,
Labour turnover (for department, for individual job),
Labour costs per unit of work (especially laundries),
Wage schedules for each position (here it is to be mentioned that no employee should need to ask for an increase in salary; it should be automatic, or he should be told that his position is worth only so much and his maximum has been reached).

The setting up of a personnel department takes time, in fact it may take years, depending on the size of the institution.

Soviet Medical News

Animal blood is being used with great success in many Soviet hospitals. Injections of 100 to 200 centimeters at a time have a positive effect on badly-wounded men, accelerating healing, raising vitality, improving appetite and sleep and curing avitaminosis. The hospitals have special herds of "donor" cows, fed chiefly on lucerne, which contains a high-percentage of Vitamin A. In one hospital 1,000 liters of blood were obtained from cattle during the past year, each "donor" supplying three to four liters twice monthly. Experiments have shown that animals can safely give over 20 liters of blood per month.

* * *

One hundred and fifty medical service detachments have entered Latvia, Lithuania and Estonia with the liberating Red Army, to combat epidemics brought in by the German occupationists and to restore medical institutions. A staff of the People's Commissariat of Health Protection and 250 doctors have left for Lithuania with plans for restoring 120 hospitals. One hundred doctors have also gone to Latvia, and on July 31st three carloads of medicines and hospital equipment were dispatched to Lithuania, accompanied by a group of doctors. *Soviet Information Bulletin*

Out of the frying pan..

By addition of our "Perma-Cast" cover this utensil may also be used as a Dutch oven.

Yes, out of our new frying pan has come a complete line of aluminum cooking ware designed and made with the same skill and care that characterizes the famous AGA COOKER—the truly modern stove.

These utensils make use of a tested principle of heat radiation that guarantees efficient performance. "Perma-cast" out of aluminum, they have *thinner* walls and *heavy bases that hold and distribute the heat where it is most needed.*

Combined with this feature is a clever handle lock that permits its removal and makes cleaning a pleasure.

We make all types of kitchen equipment

Let us solve your kitchen problems. We can advise you on the most efficient equipment for any kitchen large or small. We manufacture special apparatus to your own specifications. Perhaps it is an unusual steam table, or sink assembly, maybe you need larger working surfaces for cooking or baking. These are the things we are making daily and we will gladly estimate and advise you on your particular needs.

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• • •

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Safeguarding

(Concluded from page 27)

ease was six months. It is interesting to note that the four who had a positive tuberculin did not develop a lesion until an average of 44 months after beginning work at the sanatorium. One was after eight years, one five years, and in two it was a year.

What was the nature and seriousness of their tuberculosis? Seven had minimal pulmonary disease and one moderately advanced, discovered by routine films or at the time of conversion of their tuberculin test. Two had mediastinal adenitis, two pleurisy with effusion and one erythema nodosum. All completely recovered. This 2.3 per cent incidence of tuberculosis among sanatorium personnel is lower than in nurses of a large general hospital, according to the observation of Dr. D. L. Scott, who found that, over a ten-year period, 3.75 per cent developed some type of tuberculosis disease. During the past six years at the sanatorium only one trained nurse broke down out of a total of 110 health nurses employed, which is only .9 per cent. Out of 58 health nurses' assistants employed, however, eight or 13 per cent, broke down.

It is strikingly evident that *more instruction and closer supervision and protective immunity is needed for untrained personnel on the wards.* Finally, it is my opinion that the graduate nurse is safe in a sanatorium if she applies the knowledge she possesses, and if she does not she is not safe nursing any disease.

Address at a conference on the shortage of nurses in tuberculosis nursing, held in Winnipeg in April, and sponsored by the M.A.R.N. and the M.H.A.

Saskatchewan Plans Training in Tbc. for Student Nurses

Plans for a $12,000 addition to the nurses' residence at the sanatorium at Fort San are under consideration by the Saskatchewan government. Purpose of the addition is to provide living space for 30 student nurses, who would be specially trained in the care of tubercular patients.

It is anticipated that eventually the Anti-Tuberculosis Association will train its own nurses. Nurses specially trained in anti-tuberculosis work would thus be available for the extension of the travelling tuberculosis clinics.

Coming Conventions

September 30-October 2—American College of Hospital Administrators, Cleveland, Ohio.
October 2-6—American Hospital Association, Cleveland, Ohio.
October 2-3—Instructional Course in Hospital Administration, Vancouver, B.C.
October 4-6—British Columbia Hospitals Association, Hotel Vancouver, Vancouver.
October 17-18—Ontario Conference of the Catholic Hospitals.
October 18-20—Ontario Hospital Association, Royal York Hotel, Toronto.
October 30-31—Saskatchewan Hospital Association, Moose Jaw.
November (1st week)—Associated Hospitals of Alberta, Calgary.
November (early)—Manitoba Hospital Association.

Competition Announced for Small Hospital Plans

The Modern Hospital has announced two architectural competitions for designs for (a) a small general hospital of 40 beds and (b) a small community health centre.

A first award of $1,000 will be made in each class with a second award of $750, a third award of $500 and three honourable mentions, each of which will be $100. These awards will be paid in United States Treasury bonds. The contest is open to Canadians as well as Americans and architects, architectural students and draftsmen may compete. An architect may team with a hospital administrator, consultant or health officer.

The small hospital of 40 beds (not 25 beds as originally stated) is designed for a site of 250 by 400 feet and to serve a population of 12,500. Stipulations respecting the various services which are to be included have been published in the August issue of *Modern Hospital.*

The small community health centre is to provide facilities for the use of the local public health officer and his staff as well as offices for five physicians and two dentists with their necessary office assistants. This centre should include also a small outpatient department, a social service room, examining and treatment rooms, etc.

Full details of the competition may be obtained from the Modern Hospital Publishing Company at 919 North Michigan Avenue, Chicago 11, Illinois. The contestants must register their intention of entering the competition on or before September 30, 1944, with the architectural advisor, Karl A. Erikson, 104 South Michigan Avenue, Chicago 3. The closing date for the receipt of plans is December 1st, 1944.

The judges are: Dr. Malcolm T. MacEachern, Professor of Hospital Administration, Northwestern University; Graham Davis, hospital consultant with the Kellogg Foundation; Dr. V. M. Hoge, Chief, Hospital Facilities Section, U.S.P.H.S.; Mies van der Rohe, Professor of Architecture, Illinois Institute of Technology, Chicago; Charles Butler, architect, New York City; Nathaniel A. Owings, architect, Chicago, and Harry Shepley, architect, Boston.

Close Indian Hospitals for Lack of Nurses

Dr. Percy E. Moore, superintendent of medical services in the Indian Affairs Branch, has announced that unless the nursing staffs of the various Indian hospitals can be built up, some of these institutions will have to close down. Dr. Moore stated that the Branch had been unable to obtain additions to staffs depleted by the needs of war services and the attraction of city hospitals where regular hours of duty are assured.

One hospital, on the Morley Reserve near Calgary, has already closed down due to lack of help, and 750 Stoney Indians are left without the care normally provided for them.

Other hospitals reported in desperate need (September 1st) are that on the Peigan Reserve in Southern Alberta, which serves 700 Indians and that at Norway House in Northern Manitoba. This latter, which serves a population of about 4,000, is about to close down due to the fatigue of Dr. Cameron Corrigan, the doctor in charge, and the two remaining nurses, who are on duty 12 hours a day and more, with no prospect of holidays under existing conditions.

WANT ADVERTISEMENTS

Advertisements in this department, up to 50 words, set in single column, $1.50 per insertion. If set in box, single column, $2.00 per insertion.

DIETITIAN WANTED

A Dietitian for 150 bed hospital in Western Canada. $110.00 per month plus board, room and laundry. Apply to Box 728S, The Canadian Hospital, 57 Bloor St. West, Toronto 5, Ont.

WANTED—INSTRUCTRESS

For 75 bed hospital. Apply, stating age, qualifications and salary expected, to: Superintendent of Nurses, Lamont Public Hospital, Lamont, Alberta.

GRADUATE NURSE WANTED

A graduate nurse with Ontario Registration, for service in the Eye, Ear, Nose and Throat Department at Victoria Hospital, London, Ont. Special training in Eye work essential. Good salary. New hospital. Give full particulars to Superintendent of Nurses.

Public Education Co-operation

Successful completion by community hospitals of any public education goal will be furthered by co-operation among the several hospitals in a multi-hospital city. The Hospital Council of cities with more than one hospital would seem the logical agency to co-ordinate public education methods and objectives.

An increase in public opinion favourable to hospitals has been noted in the cities in which the Councils are active in public education. On a commonsense basis it would seem practical to avoid confusion and duplication of efforts by an interchange of schedules and plans of individual hospitals.

To lessen the drain on the administrator's time it is suggested that each hospital have one person responsible for carrying out the administrator's programme of public education. The ideal situation, of course, is to have a full-time public relations employee if practical. Many hospitals have successfully utilized the volunteer services of a newspaper reporter, advertising man, or public relations counsellor. In this instance, as in any other, it is essential that one person be responsible for making contacts, delivering newspaper stories, arranging and maintaining schedules, etc., always under the direction of the administrator. In the smaller institution this is not a full-time job. In larger hospitals it might be, but a great deal can be accomplished by several hours volunteer work weekly. The administrator, by appointing someone responsible for public education activities, is relieved of at least some of the details necessary to accomplish any such programme.

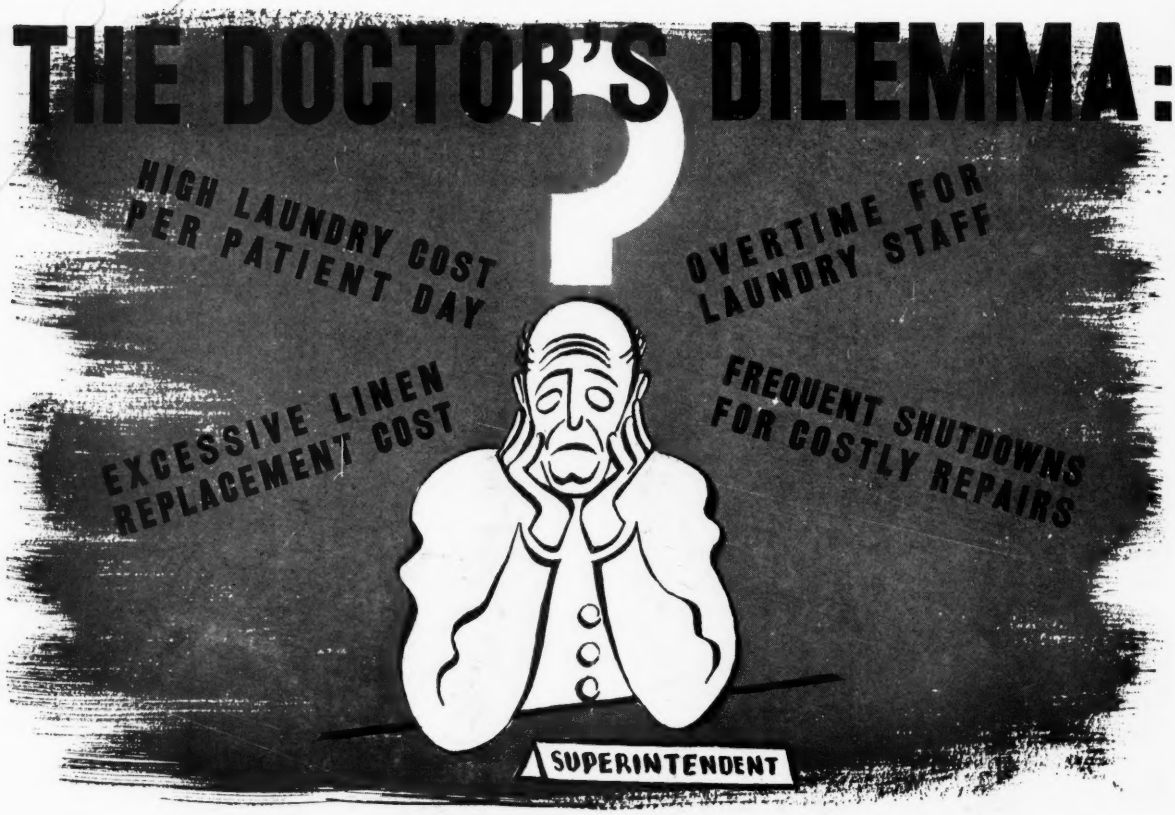
The public relations assistant or volunteer and the administrator of each hospital in a city with more than one hospital can develop a greater publicity impact upon their communities by co-ordinating their efforts upon certain occasions. National Hospital Day is certainly an occasion important enough to warrant such co-operation.

—From the Bulletin of the Council on Public Education, American Hospital Association.

Index of Advertisers

SEPTEMBER, 1944

THE DOCTOR'S DILEMMA:



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